Tranquility Adventist School

"Educating for Eternity"

3 Academy Lane, Andover, NJ 07821
(908) 852-1391
www.tranquilityschool.com
principal@tranquilityschool.com

Medical Health Forms

- Physicals every year- Due September 1st and immunizations should be updated each year.

  School Universal Health Forms (MUST BE COMPLETED – **New Students OR Returning students in GRADES K,1, 4, 7-** **https://www.state.nj.us/health/forms/ch-14.pdf**

- Permission Form for Nursing Services
- Health Inventory /Medical Up-date
- Allergy/and or Asthma Forms (if applicable)- **Must** be completed by Physician- Medications if required **must** be received by the first day of school.

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SCHOOL HEALTH SERVICES HISTORY FORM

(TO BE COMPLETED BY PARENT/GUARDIAN) *The information provided is confidential.*

Name of Child (last)	(first)	(middle)
Date of Birth	Grade	Date of last physical exam
Date of last dental exam	Dentist Name	Dentist Phone #

DISEASE/DISORDER HISTORY OR ILLNESS

	Yes	No		Yes	No
Allergies/Environmental			**Eating Disorder**		
Allergies/Food			**Endocrine Disorder**		
Allergies/Insect Stings or Bees			**Head or Spinal Injury**		
Allergies/Latex			**Headaches/Migraines**		
Allergies/Medications			**Hearing Problem**		
Allergies/Other			**Heart Defect or Disease**		
Asthma/Breathing Disorder			**Hepatitis or Liver Problem**		
Behavioral Disorder			**Hypertension**		
Bladder/Kidney Disorder			**Immune System Disorder**		
Bleeding/Clotting Disorder			**Mobility Limitation**		
Bone/Joint/Muscular Disorder			**Psychological/Emotional Problem**		
Cancer			**Scoliosis**		
Convulsions/Epilepsy/Seizure			**Skin Condition**		
Developmental Disorder			**Urinary/Bladder/Kidney Disorder**		
Dizziness or Fainting			**Speech Disorder**		
Diabetes			**Surgery or Hospitalization**		
Dietary Restriction			**Vision or Eye Disorder**		
Digestive/Bowel Disorder			**Other (explain below)**		

OTHER MEDICAL CONDITION:

_____

Was a medical evaluation performed for any condition/disorder checked 'yes'?: Yes_____ No_____

OVER ⟶

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My child is under a doctor's care for Asthma: Yes_____ No_____

If yes, medications taken: _____

*__An *Asthma Action Plan* form will need to be completed by the Doctor.__

My child is under a doctor's care for a Severe Allergy to:

_____

Please describe the allergic reaction:

_____

Was an Epi-Pen prescribed? : Yes_____ No _____

*__An *Allergy Action Plan* form will need to be completed by the Doctor.__

My child is under a Doctor's care for Diabetes: Check type: Type 1_____ Type 2 _____

*__A *Diabetic Medical Management Plan* will need to be completed by the Doctor.__

MEDICATION HISTORY

Does your child take medication on a daily basis (include homeopathic and nutritional supplements)?

Yes_____ No_____

Please list all medications taken and what the medication or supplement is for:

Yes___ No___ **CONSENT TO SHARE INFORMATION**: The school nurse and/or health aide has my permission to share my child's confidential health information, on a need-to-know basis, with appropriate members of the educational staff and primary healthcare providers for use in meeting the educational and health needs of my student. The consent includes the sharing of personally identifiable health record information during immunization and communicable disease surveillance.

Parent/Guardian Signature: _____ Date: _____

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Permission Form for Nursing Services
School Year _____

To: Parent/ Guardian

From: School Nurse

Re: Nursing Services; Chapter 226 – Laws of 1991

Existing legislation provides certain nursing services and funding for full time students in private schools. Included in these services, based on available state aid, is maintenance of student health records, hearing assessment, vision screening, height and weight measurements and scoliosis screenings. In addition, your child will receive emergency nursing services for any school related illness or injury.
Please sign the form below and return it to my office ASAP.
Thank you.

PERMISSION FOR SCREENINGS

HEARING SCREENING	YES	NO
VISION SCREENING	YES	NO
SCOLIOSIS (GRADES 5, 6, 7, 8, 9, 10,11,12)	YES	NO
HEIGHT AND WEIGHT/ BLOOD PRESSURE	YES	NO
EMERGENCY TREATMENT	YES	NO

Name of the student _____ in Grade _____

Parent Signature _____ Date_____

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Dental Form Certificate

Dear Parent/Guardian:

The School health policy recommends an annual dental examination by your family dentist for each child.

The form below is to be completed. If your child has had an examination in the last six (6) months, please have the dentist complete this form.

Please return this form to the school as soon as possible following your child's dental examination.

I have examined:

Student's Name: _____

Date: _____

☐ 1. There is no need for corrective work at this time.

☐ 2. Treatment has been completed

☐ 3. There is need for dental care at this time:
Has an appointment been scheduled □ YES □ NO

_____

Dentist's Signature ***Date***

Printed Name and Address of Dentist:

_____

_____

_____