Summit Public Schools Supplemental Health Questionnaire

(To meet legal requirements, we are sending this home to be completed. In the future, we hope to include it as part of our online registration system.)

School: _____ Grade: _____

Student Name: _____
Last First

A message regarding my child's health can be left on my home# _____ Cell# _____or E-mail _____

Emergency contacts on file may be called for authorization of medical treatment/decisions Yes ___ No ___

Does child have Health Insurance?
Yes _____ If yes, name of insurance company _____
No _____NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information call 800-701-0710 or visit www.njfamilycare.org to apply online.

You may release my name and address to the NJ FamilyCare Program to contact me about health insurance.

Signature: _____Printed Name: _____Date: _____
Written consent required pursuant to U.S.C. § 1232g(b)(1) and 34 C.F.R. 99.30 (b).

Medication currently taken: _____

Any known allergies: (complete if you did not add them to the online registration) _____
_____

Illnesses, accidents, or operations in the past year (names and dates): _____
_____

Immunizations received in the past year (names and dates): _____

Current Medical conditions/restrictions:

Does your child wear glasses? _____ Contacts? _____
They are to be worn: At all times _____ For school work_____
For distance_____ For reading_____
Does your child have a hearing problem? Yes_____ No_____
Please explain: _____
Orthodontist: _____ Phone: _____

Please check the appropriate box:

_____ I PERMIT the above health information to be shared with the teaching staff.
_____ I DO NOT permit the above health information to be shared with the teaching staff.

Signature of Parent/Legal Guardian _____ Date_____