Wall Township Public Schools

Yearly Health Update

Dear Parent/Guardian:

In order to provide the best possible health services for your child, the school nurse needs to know your child's health history and current health status. Your response to this letter will allow us to update your child's school health file. Please indicate below if the following apply to your child. If you require a consultation with the school nurse please contact your child's school.

Any student exhibiting symptoms consistent will be directed to the nurse for further evaluation. Students exhibiting symptoms consistent with COVID 19 or other highly transmissible viruses may be asked to wear a mask in the health office as they wait to be picked up by a parent or approved emergency contact. Students must be picked up by a parent or approved emergency contact within 30 minutes of notification.

NOTE: Parents must review and update their child's health records and emergency contact information immediately. Emergency contacts should be authorized persons who are readily available to pick up students who are ill no later than 30 minutes from notification by the nurse.

- ❏ Asthma
  - ❏ Requires Medication: Fill out Asthma Treatment Plan and Medication Request Form (Please note due to added precautions, nebulizers will not be administered this year).

- ❏ Food Allergies_____
  - ❏ Requires Medication Click here to fill out required forms

- ❏ Other Allergies_____
  - ❏ Requires Medication Click here to fill out required forms

- ❏ History of Serious Injury or Illness:_____

- ❏ Hospitalizations/Surgeries: _____

- ❏ Diabetic (Please contact your school nurse and fill out BOTH the Medication Request Form and Diabetic Management Plan)

- ❏ Seizure Disorder (Please contact your school nurse and fill out BOTH the Medication Request Form and Seizure Action Plan

- ❏ ADD/ADHD

- ❏ Wears Glasses or Contacts, if YES Date Obtained: _____

History of: Cardiac Problem ____ Cancer ____ Immune Disease ____ Transplant ____
Please Explain: _____

Any other health conditions we should be aware of: _____

Please list any Current Medications taken at home: _____

Do any medications need to be taken during school hours? _____ If YES, please fill out Medication Request Form

❏ NONE OF THE ABOVE

Child's Name _____ Date: _____

Grade/Teacher: _____

I give permission for the school nurse to share information concerning my child's health to those faculty/staff members who may need to know. I recognize that sharing this information is important to my child's well being while attending school.

Signature: _____ Date: _____

Additionally, we would like to remind you that yearly physical examinations are recommended for all children of school age. We would appreciate a record of your child's most recent physical exam.

Sincerely,

District School Nurses