ST	JDENT'S NAME:		
1.	Has your child had any immunizations during the past year?  If yes, please list and provide a copy of your child's immunization record.	YES	NO
2.	Has your child had any major illness, injury, surgery, or hospitalization? If yes, please explain.	YES	NO
3.	Is your child on any daily medications?  If yes, please explain.	YES	NO
4.	Does your child have asthma?  Does he/she use a rescue inhaler?  If yes, please call the school nurse to discuss medication at school.	YES YES	NO NO
5.	Has your child ever been advised not to participate in any activity or sport? If yes, please explain.	YES	NO
6.	Is your child presently under the care of a physician? If yes, please explain.	YES	NO
	Please note any other health information you feel is valuable for your child's school nurse to know:		
	I UNDERSTAND MY CHILD'S HEALTH HISTORY MAY BE SHA APPROPRIATE SCHOOL PERSONNEL, WHEN NECESSA		
	Parent/Guardian Signature	Date	

<sup>\*\*</sup> See Reverse for Additional Questions \*\*

STUDENT'S NAME:		
SCOLIOSIS SCREENING	Υ	ES NO
Completed for students in grades 4, 6, 8		
If you do not wish your child to have a scoliosis screening from your child's health care provider	ng, please provide a copy of	a recent screening
Does your child have health insurance?	Y	ES NO
NJ FamilyCare provides free or low-cost health insurance	ce for uninsured children an	d certain
low-income parents. May NJ FamilyCare contact you?	Υ	ES NO
If yes, please sign below:		
You may release my name and contact information to t	he NJ FamilyCare program.	
	=	
Parent/Guardian Signature	D	ate
Name three persons you authorize to transport your ch	ild and/or to be contacted i	n an emergency:
1	Phone:	
2.		
3.		
AUTHORIZATION FOR MEDICAL TREATMENT		
1. I, the undersigned, do hereby authorize officials at 0	Greenwich Township School	District to contact
the above-named persons named and do authorize	the appropriate school pers	sonnel to render firs
aid as may be deemed necessary in an emergency for	or the health of said child,	
2. If the parents or above-named persons cannot be co	ontacted, the school official	s are hereby
authorized to take whatever actions deemed necess	sary in their judgment, for t	he health of the said
child, including transportation to the nearest medic	al facility.	
	-	
Parent/Guardian Signature	D	ate

ST	UDENT'S NAME:		
1.	Has your child had any immunizations during the past year? If yes, please list and provide a copy of your child's immunization record.	YES	NO
2.	Has your child had any major illness, injury, surgery, or hospitalization? If yes, please explain.	YES	NO
3.	Is your child on any daily medications? If yes, please explain.	YES	NO
4.	Does your child have asthma?  Does he/she use a rescue inhaler?  If yes, please call the school nurse to discuss medication at school.	YES YES	NO NO
5.	Has your child ever been advised not to participate in any activity or sport? If yes, please explain.	YES	NO
6.	Is your child presently under the care of a physician? If yes, please explain.	YES	NO
	Please note any other health information you feel is valuable for your child's school nurse to know:		
	I UNDERSTAND MY CHILD'S HEALTH HISTORY MAY BE SHAF APPROPRIATE SCHOOL PERSONNEL, WHEN NECESSA		
	Parent/Guardian Signature	Date	

<sup>\*\*</sup> See Reverse for Additional Questions \*\*

STUDENT'S NAME	::			
Does your child h	ave health insurance?		YES	NO
NJ FamilyCare pro	ovides free or low-cost health insuranc	e for uninsured childre	n and certain	
low-income parer	nts. May NJ FamilyCare contact you?		YES	NO
If yes, please sign				
You may release	my name and contact information to tl	ne NJ FamilyCare progr	am.	
Parent/Guardian	 Signature		Date	
Nigoro e thougan a grand		:!		
	ons you authorize to transport your ch			
3.		Phone:		
AUTHORIZATION	FOR MEDICAL TREATMENT			
	gned, do hereby authorize officials at G	•		
	med persons named and do authorize		-	render firs
· ·	deemed necessary in an emergency for above named persons cannot be so			ohv
•	If the parents or above-named persons cannot be contacted, the school officials are hereby authorized to take whatever actions deemed necessary in their judgment, for the health of the said			
	g transportation to the nearest medical	, , ,	ior the nearth	i or the sale
cima, meradin	a comportation to the hearest medica	a. radincy.		
Parent/Guardian	Signature		Date	

ST	UDENT'S NAME:		
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2.	Has your child had any major illness, injury, surgery, or hospitalization? If yes, please explain.	YES	NO
3.	Is your child on any daily medications? If yes, please explain.	YES	NO
4.	Does your child have asthma?  Does he/she use a rescue inhaler?  If yes, please call the school nurse to discuss medication at school.	YES YES	NO NO
5.	Has your child ever been advised not to participate in any activity or sport? If yes, please explain.	YES	NO
6.	Is your child presently under the care of a physician? If yes, please explain.	YES	NO
	Please note any other health information you feel is valuable for your child's school nurse to know:		
	I UNDERSTAND MY CHILD'S HEALTH HISTORY MAY BE SHA		
	Parent/Guardian Signature	Date	

<sup>\*\*</sup> See Reverse for Additional Questions \*\*

Parent/Guardian Signature	 Date	
aid as may be deemed necessary in an emergency for the health of said child,  If the parents or above-named persons cannot be contacted, the school officials are hereby authorized to take whatever actions deemed necessary in their judgment, for the health of the said child, including transportation to the nearest medical facility.		
1. I, the undersigned, do hereby authorize offici the above-named persons named and do aut	horize the appropriate school personnel	
AUTHORIZATION FOR MEDICAL TREATMENT		
3	Dhana	
1		
Parent/Guardian Signature  Name three persons you authorize to transport y  1.		
You may release my name and contact informati	on to the NJ FamilyCare program.	
If yes, please sign below:		
low-income parents. May NJ FamilyCare contact	you? YES	NO
Does your child have health insurance?  NJ FamilyCare provides free or low-cost health in	YES surance for uninsured children and certa	NO in
If you do not wish your child to have a scoliosis so from your child's health care provider	creening, please provide a copy of a rece	nt screening
Completed for students in grades 4, 6, 8		
SCOLIOSIS SCREENING	YES	NO
STUDENT'S NAME:		
CTUDENT'S NAME.		