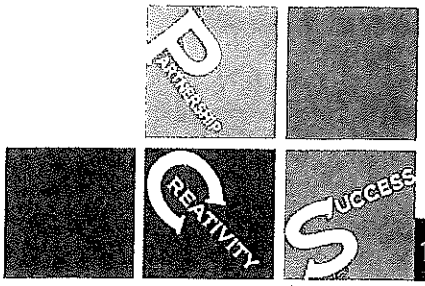

Vineland Public Charter School

1480 Pennsylvania Ave, Vineland, NJ 08360 | Phone: 856-691-1004

Annual Medical Form

Student Name:_____D.O.B._____M/F_____Grade_____

Home Address: _____

Home Phone_____ Best number to call during school hours_____

Mother's Name_____ Father's Name _____

Mother's Cell_____ Mother's Work Phone: _____

Father's Cell_____ Father's Work Phone: _____

Emergency contact: _____

1. Does your child take any medications? Yes [ ] No [ ]

   If yes, please explain_____

   What time of day does your child take these medications?_____

2. Does your child have a history of asthma Yes [ ] No [ ] If yes does your child require medication during school Yes [ ] No [ ]
3. Does your child have any medical or physical problems? Yes [ ] No [ ]

   If yes, please explain:_____

4. Does your child have any allergies? Yes [ ] No [ ]

   If yes, please explain:_____

5. Is there any food that your child cannot eat? Yes [ ] No [ ]

   If yes, please explain:_____

6. Does your child have a history of convulsions or seizures? Yes [ ] No[ ]
   If yes, please explain:_____

   Names of medication(s):_____

7. Has your child ever had any serious illness, operations, dental work or accidents? Yes [ ] No [ ]
   If yes, please explain, include date and incident:_____
8. Was your child's birth considered by your doctor to be premature, unusually traumatic or difficult? Yes [ ] No[ ] If yes, please explain:_____
9. Has your child been exposed to toxic substances such as lead, pesticides, inhalants, etc.? Yes [ ] No [ ] If yes, please explain:_____
10. Does your child wear glasses or contacts? Yes [ ] No [ ] If yes, how old is this pair?_____
11. Has your child recently had a traumatic or upsetting experience such as the death of someone close, family divorce, moving to a new home, witnessed a violent act or being the victim of a violent act, having someone close to your child seriously ill or injured? Yes [ ] No[ ] If yes, please explain:_____
    _____
    _____
12. Does your child display any signs of emotional problems, such as frequent uncontrolled outbursts, withdrawal/inability to relate to others, lying to parents/guardians? Yes [ ] No [ ] If yes, please explain:_____
13. Name of Doctor:_____ Phone number _____
    Date of last healthcare visit _____
14. Name of Dentist:_____ Phone number_____
    Date of last dentist visit:_____
15. Girls only—Date of onset of menstruation_____Date of last cycle_____
16. Do you have any further comment, concerns or significant information that you feel would be important for the school nurse or staff to know?
    _____
    _____

***The above health information is pertinent to the safety and well being of your child. Please indicate below if we may advise the appropriate staff members.

[ ] Yes, I give permission to share this information with necessary staff members.

[ ] No, I DO NOT give permission to share this information with necessary staff members.

Signature of Parent/Guardian_____

Date_____