

BLOOMSBURY ELEMENTARY SCHOOL

Student Health Information Update

Student Name _____ Birth date _____ Grade _____

Part I. Health Insurance

Does student have health insurance including NJ Family Care/Medicaid, Medicare, private or other?

YES, name of insurance company _____

NO, my child does not have health insurance. You may release my name and address to the NJ Family Care Program to contact me about health insurance. NJ Family Care provides free or low cost health insurance for uninsured children and certain low income parents. For more information please call 800-701-0170 or visit www.nifamilycare.org to apply on line.

Signature _____ Date _____

Written consent required pursuant to 20 U.S.C. § 1232g (b)(1) and 34 C.F.R. 99.30(b)

Part II. Medical Information/Health History Update

Please check below to update:

Physical exam _____

Current Medications _____

Recent immunizations (past year) _____

Allergies (any allergies or recent reactions) _____

Asthma (name of current medications) _____

Serious Illness/Disease _____

Hospitalization _____

Restrictions _____

Dental exam _____

Eye exam date _____

Glasses or contacts close work distance wear all the time

Other _____

There have been no changes in my child's health.

Family Doctor: _____ Phone Number: _____

Family Dentist: _____ Phone Number: _____

Hospital Preference: _____

I, the undersigned do hereby authorize officials of the Bloomsbury School District to contact me directly and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of said child. In the event that physicians or parents cannot be contacted, school officials are hereby authorized to take whatever action is deemed necessary in their judgement, for the health of the aforesaid child. I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

Parent/Guardian Signature: _____ Date: _____

Part III. Consent for Release of Health Information

The *Family Educational Rights and Privacy Act (FERPA)* prohibits the sharing of medical and health information without parental consent. The district would like permission to share information relative to allergies, asthma, hearing and vision considerations, special diets, and certain medical conditions (i.e. heart problems, spina bifida, lactose intolerance, cystic fibrosis, etc.) with faculty and staff members.

Yes, you may share relevant medical/health information affecting my child's safety with faculty and staff.

No, you may not share my child's medical/health information. I release the Bloomsbury Board of Education, its officers, employees, agents, and representatives from any and all claims, liability or damages related to incidents where relevant health/medical information was not shared.

Parent/Guardian Signature: _____ Date: _____