CHRISTIAN BROTHERS ACADEMY

850 Newman Springs Road
Lincroft, NJ 07738
732-747-1959 x 206

Please complete this form and return it along with the Annual Physical form to the nurse's office in the enclosed envelope by August 6th. Faxes and emails are also acceptable.

Student Name_____ DOB _____ Class of 20 ___

Does your child have any allergies? _____No _____Yes (if yes, please provide an allergy action plan)

My child is allergic to: _____

History of Anaphylaxis? _____No _____Yes

Does your child have asthma? _____No _____Yes (if yes, please provide an asthma action plan)

Does your child have diabetes? _____No _____Yes (if yes, please provide a diabetes care plan)

Does your child have epilepsy/seizures? _____No _____Yes (if yes, please provide a seizure action plan)

Has your child ever had a concussion? _____No _____Yes

Is there any other health/medical concerns the nurse should be aware of? (If yes, please indicate below)

_____

_____

_____

10th & 12th Grade Only: Do you consent to the school nurse performing scoliosis screening? ____ No ____ Yes

Does your child require daily medication at school? _____No _____Yes (State law requires written authorization from a doctor and parent before any medication, prescription or over-the counter, can be given at school.)

Please note that health information may be shared with staff on a "need to know basis", to ensure the safety and well-being of your child.

*****If any changes in your child's health should occur, please contact the nurse's office to update your child's health information.

Parent Name _____ School Year 2021-22
Please print clearly

Parent's Signature_____ Date_____

Thank you,

Patricia Falconite RN *Denise Bailey RN* *Colleen Straine RN*

Fax: 732-530-1438 *email: nurse@cbalincroftnj.org*