



# 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 Evaluation forms to the nurse's office in the enclosed envelope by August 1<sup>st</sup>.

Student Name \_\_\_\_\_ Grade \_\_\_\_\_

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): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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's Signature \_\_\_\_\_ Date \_\_\_\_\_

Thank you,  
Patricia Falconite RN  
Denise Bailey RN  
Colleen Straine RN