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 by Friday, August 2, 2024.

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 along with any emergency medication)

Has your child ever had a concussion? _____NO _____YES

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

_____

_____

10th and 12th grade only: Do you give consent for the school nurse to perform a 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 after completing this form, please contact the nurse's office to update your child's information.

Parent/Guardian Signature:_____Date:_____

Thank you,

Patricia Falconite, R.N.
Denise Bailey, R.N.
Colleen Straine, R.N.

See reverse

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CONFIDENTIAL STUDENT HISTORY (Be sure to check ALL categories and include dates. A section for comments is provided below)

Trouble w/Hearing:_____

Hearing Aid:_____

Trouble w/Speech:_____

Trouble w/Vision:_____

Wears Glasses:_____

Wears Contact Lenses:_____

Frequent Ear Infections:_____

Frequent Sore Throats:_____

Frequent Headaches:_____

Diabetes:_____

Seizures:_____

Gastrointestinal issues:_____

Concussion:_____

Faints Easily:_____

Wheezing/Asthma:_____

Bee Sting Allergy:_____

Attention Deficit Disorder:_____

Eating Disorder:_____

Trouble Sleeping:_____

Anxiety:_____

Depression:_____

Previous Child Study Team Referral:

_____

Other:_____

Comments:_____

_____

_____

_____

Is the student taking any medication on a regular basis? Yes _____ No _____

If yes, please specify for what condition:_____

If yes, please specify the name, dosage strength and how often the medication is administered:_____

Are there any problems or special considerations you feel the school should be aware of in working with your child? Yes_____ No_____

If yes, please comment: _____

_____

_____

Parent/Guardian signature:_____Date:_____

See reverse