

# Health form



Child's name \_\_\_\_\_  
(Please print clearly) Last First Middle

Birth date \_\_\_\_\_ Age \_\_\_\_\_  Male  Female

Address \_\_\_\_\_  
City State Zip

E-mail address \_\_\_\_\_

Phone \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_  
Home Business Cellular Beeper

## STATEMENT for PARENT'S SIGNATURE

*My child has been immunized in compliance with New Jersey state law. My child has had a physical examination within the last year and was found to be physically able to participate in athletic and summer activities.*

*I, the undersigned, do hereby authorize officials of The Elisabeth Morrow School to contact directly the persons named on this report and do authorize the named physician to render such treatment necessary in an emergency for the health of said child. In the event the physician, other persons named on this report or parents cannot be contacted, the School officials are hereby authorized to take whatever action is deemed necessary in their judgment for the health of the aforesaid child. I will not hold the School financially responsible for the emergency care and/or transportation for said child.*

*I give my permission for the School nurse to share all health information with the faculty and staff as needed. Should any of the above information require updating at any time, I will directly advise the School of such changes.*

\_\_\_\_\_  
Signature of parent or guardian

\_\_\_\_\_  
Date

## EMERGENCY CONTACTS

1. Name \_\_\_\_\_

Phone \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_  
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2. Name \_\_\_\_\_

Phone \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_  
Home Business Cellular

3. Pediatrician \_\_\_\_\_ Phone \_\_\_\_\_

Does the student have any medical or other problems that should be made known (i.e. recent illness, chronic illness, asthma, allergies...)? If so, please describe.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are there any significant medical, neurological, psychological, or other conditions that would affect the experience of your child or others in Summer Explorations? If so, please describe.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is the student taking any medications? Please include all prescription and non-prescription drugs, ointments, inhalers, etc.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Important: Foreign students must present proof of a recent Mantoux Tuberculosis Test. If it is positive, a chest X-ray and any other necessary treatment must be taken.**