

Tranquility Adventist School

“Educating for Eternity”



📍 3 Academy Lane, Andover, NJ 07821

☎ (908) 852-1391

🌐 www.tranquilityschool.com

✉ principal@tranquilityschool.com

📞 (215) 932-3893

Medical Health Forms

- Physicals every 3 years Grades K, 1, 4, 7 - Due September 1st and immunizations should be updated each year.

School Universal Health Forms (MUST BE COMPLETED – New Students OR Returning students in GRADES K,1, 4, 7- <https://www.state.nj.us/health/forms/ch-14.pdf>)

- Permission Form for Nursing Services
- Health Inventory /Medical Up-date
- Allergy/and or Asthma Forms (if applicable)- **Must** be completed by Physician- Medications if required **must** be received by the first day of school.

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SCHOOL HEALTH SERVICES HISTORY FORM

(TO BE COMPLETED BY PARENT/GUARDIAN) *The information provided is confidential.*

Name of Child (last)	(first)	(middle)
Date of Birth	Grade	Date of last physical exam
Date of last dental exam	Dentist Name	Dentist Phone #

DISEASE/DISORDER HISTORY OR ILLNESS

	Yes	No		Yes	No
Allergies/Environmental			Eating Disorder		
Allergies/Food			Endocrine Disorder		
Allergies/Insect Stings or Bees			Head or Spinal Injury		
Allergies/Latex			Headaches/Migraines		
Allergies/Medications			Hearing Problem		
Allergies/Other			Heart Defect or Disease		
Asthma/Breathing Disorder			Hepatitis or Liver Problem		
Behavioral Disorder			Hypertension		
Bladder/Kidney Disorder			Immune System Disorder		
Bleeding/Clotting Disorder			Mobility Limitation		
Bone/Joint/Muscular Disorder			Psychological/Emotional Problem		
Cancer			Scoliosis		
Convulsions/Epilepsy/Seizure			Skin Condition		
Developmental Disorder			Urinary/Bladder/Kidney Disorder		
Dizziness or Fainting			Speech Disorder		
Diabetes			Surgery or Hospitalization		
Dietary Restriction			Vision or Eye Disorder		
Digestive/Bowel Disorder			Other (explain below)		

OTHER MEDICAL CONDITION:

Was a medical evaluation performed for any condition/disorder checked 'yes'? Yes _____ No _____

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My child is under a doctor’s care for Asthma: Yes _____ No _____

If yes, medications taken: _____

***An Asthma Action Plan form will need to be completed by the Doctor.**

My child is under a doctor’s care for a Severe Allergy to:

Please describe the allergic reaction:

Was an Epi-Pen prescribed? : Yes _____ No _____

***An Allergy Action Plan form will need to be completed by the Doctor.**

My child is under a Doctor’s care for Diabetes: Check type: Type 1 _____ Type 2 _____

***A Diabetic Medical Management Plan will need to be completed by the Doctor.**

MEDICATION HISTORY

Does your child take medication on a daily basis (include homeopathic and nutritional supplements)?

Yes _____ No _____

Please list all medications taken and what the medication or supplement is for:

Yes ___ No ___ **CONSENT TO SHARE INFORMATION:** The school nurse and/or health aide has my permission to share my child's confidential health information, on a need-to-know basis, with appropriate members of the educational staff and primary healthcare providers for use in meeting the educational and health needs of my student. The consent includes the sharing of personally identifiable health record information during immunization and communicable disease surveillance.

Parent/Guardian Signature: _____ Date: _____

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Permission Form for Nursing Services School Year _____

To: Parent/ Guardian

From: School Nurse

Re: Nursing Services; Chapter 226 – Laws of 1991

Existing legislation provides certain nursing services and funding for full time students in private schools. Included in these services, based on available state aid, is maintenance of student health records, hearing assessment, vision screening, height and weight measurements and scoliosis screenings. In addition, your child will receive emergency nursing services for any school related illness or injury.

Please sign the form below and return it to my office ASAP.

Thank you

PERMISSION FOR SCREENINGS

HEARING SCREENING	YES	NO
VISION SCREENING	YES	NO
SCOLIOSIS (GRADES 5, 6, 7, 8, 9, 10,11,12)	YES	NO
HEIGHT AND WEIGHT/ BLOOD PRESSURE	YES	NO
EMERGENCY TREATMENT	YES	NO

Name of the student _____ in Grade _____

Parent Signature _____

Date _____

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Dental Form Certificate

Dear Parent/Guardian:

The School health policy recommends an annual dental examination by your family dentist for each child.

The form below is to be completed. If your child has had an examination in the last six (6) months, please have the dentist complete this form.

Please return this form to the school as soon as possible following your child's dental examination.

I have examined:

Student's Name: _____

Date: _____

- 1. There is no need for corrective work at this time.
- 2. Treatment has been completed
- 3. There is need for dental care at this time:
Has an appointment been scheduled YES NO

Dentist's Signature

Date

Printed Name and Address of Dentist:

