M1: Pilgrim Academy - Medical Information Form

Student Information		
Last Name:	First Name:	Middle Name:
Siblings at Pilgrim:		
Address:		
Home #:	Student's Cell#:	
DOB:	Grade 2019-2020 School Year	
Student's email:		
Who is the student's legal guardian/s?		
Who does the student live with?		

Primary Contact: Parent/Guardian Information		
Last Name:	First Name:	
Street Address (if different than the student):		
Home #:	Cell#:	Accept texts? [ ] N [ ] Y
Employer:	Work #	
Email:		

Secondary Contact: Parent/Guardian Information		
Last Name:	First Name:	
Street Address: (if different than the student):		
City	State	Zip Code
Home #:	Cell#:	Accept texts? [ ] N [ ] Y
Employer	Work #	
Email:		
Is this person authorized to pick up the child if they become ill during school hours?	[ ] No [ ] Yes	

Emergency Contact Information		
Last Name:	First Name:	
Home Phone #	Cell #:	Work #
Is this person authorized to pick up the child if they become ill during school hours?	[ ] No [ ] Yes	

Medical Condition Information

Chronic Conditions: Does the student suffer from any Chronic or Ongoing Condition/s:

Special Instructions related to Chronic Conditions:

Recent Onset Conditions: Has the student been treated in the last year for any ANY illness? If so, what?

Specific instructions related to the current illness.

Has the student experienced any of the following?

[ ] Allergies requiring an EPI-PEN
[ ] Asthma requiring the use of an inhaler and/or nebulizer
[ ] Chest pain/palpitations or other cardiac disorders, please list.
[ ] Concussion or loss of consciousness after injury
[ ] Diabetes requiring insulin
[ ] Surgery or broken bones: ____________________
[ ] Inability to participate in sports?
[ ] Tetanus: Has student received a tetanus injection in the last year? Please list place and date: ________
[ ] Any condition that requires the administration of medication during school hours? Please elaborate:
____
____

Please note: ANY medication to be given during school hours requires the parent/guardian and physician complete/sign the Medication Authorization Form.

Medication Information

Medications Taken at Home

Medication: ____________	Dose: ____________ Frequency: ________
Medication: ____________	Dose: ____________ Frequency: ________
Medication: ____________	Dose: ____________ Frequency: ________

Medications To Be Taken at School:
(Note: Script/Written permission from the physician is Required to give ANY medication during school hours, including over the counter medications).

Medication: ____________	Dose: ____________ Frequency: ________
Medication: ____________	Dose: ____________ Frequency: ________
Medication: ____________	Dose: ____________ Frequency: ________

Physician Information

Physician's Name:	Name of Practice/Office:	
Phone #	Fax#	
When was the student last seen by the physician? Date:		

Insurance Information

Does student have health insurance?
[ ] Yes: Insurance: ____________________ Policy Holder: ____________________

[ ] No: My child does not have insurance. You may release my name and address to the NJ Family Care Program to contact me about health insurance.

Signature: ________________ Printed Name: ________________ Dated: ________________

NOTE: School Insurance: The school carries a student accident insurance policy on every student. This policy is a 24 hour policy, for school activities only – including athletics, but it does have certain limits. It may not pay the entire claim. A parent's insurance is always primary. A synopsis of the coverage afforded through the school is available upon request. If parents take a student for medical treatment for a school related injury, a claim form can be secured from our school nurse or receptionist.

Allergies

Is your child ACUTELY allergic (hives, breathing problems, etc.) to any particular allergen (insect stings, nuts, etc.) ?
[ ] No [ ] Yes

Has an EPI-PEN been prescribed for the student?
[ ] No [ ] Yes. If yes, please fill out the EPI-PEN administration form.

Allergen: ____________________	Reaction: ______________	EPI-PEN? [ ] No [ ] Yes
Allergen: ____________________	Reaction: ______________	EPI-PEN? [ ] No [ ] Yes
Allergen: ____________________	Reaction: ______________	EPI-PEN? [ ] No [ ] Yes

Special instructions concerning allergies: (i.e. for a nut allergy; is it a severe nut allergy where the student can not even be in contact with nuts or a severe reaction will occur.)

Is There Anything You Want the Nurse to Know?