MONTGOMERY TOWNSHIP SCHOOLS
Skillman, New Jersey

SCHOOL HEALTH SERVICES

Student's Name: _____ **Date of Birth:** _____
(Please Print)

Gender: Male / Female (circle one)

My child previously attended a Montgomery Twp. School? Yes / No (circle one)

If yes, circle last school attended OHES VES LMS UMS MHS

HEALTH HISTORY

Has Your Child Had:	NO	YES	YEAR
Chicken Pox			
Heart Problems			
Kidney Problems			
Bladder Problems			
Asthma			
Bronchitis			
Strep Infection			
Mononucleosis			
Diabetes			
Convulsions			
Hepatitis			
Rheumatic Fever			
Pneumonia			

Does your Child Have:	YES/TYPE	NO
Congenital Defects		
Drug Sensitivities		
Neuromuscular Disease		
Speech Problems		
Vision Problems		
Eyeglasses		
Hearing Problems		

Has your child had:	If yes, description and date.
Any severe injury?	
Any operations?	

Initial the statement that applies to your child:

___ My child does **not** have a life-threatening allergy requiring the use of epinephrine.

___ My child has a life-threatening allergy requiring the use of epinephrine.
Please complete the Life-Threatening Allergy Questionnaire on the following page.

Parent/Guardian Signature: _____ Date: _____

Montgomery Township Schools

Life-Threatening Allergy Questionnaire

Complete this form only if your child has a life-threatening allergy and is entering grades:
Pre-K, Kindergarten - 4

Student's Name: _____ For School Year: _____

Date of Birth: _____ My Child will be in the following grade during the School Year indicated above: ___

1. **List only life-threatening allergens (food and non-food):**

   _____

2. **Does your child have a prescribed epinephrine auto-injector?** ☐ **Yes*** ☐ **No**
   **A health care provider completed Montgomery Township School District Emergency Allergy Action Plan (EAAP) is required if your child has a life-threatening allergy indicating the use of epinephrine in school. This EAAP and other forms can be obtained through your child's school nurse. Forms must be renewed every school year.*

3. **Will your child carry an epinephrine auto-injector in their backpack in addition to the one kept in the health office?** ☐ **Yes*** ☐ **No** *Refer to the 'Capacity for self-administration of epinephrine' section on the EAAP for an explanation of carrying options. *Your child's health care provider must check either the 1st or 2nd option for authorization to carry. Please note, if your child carries a set of epinephrine auto-injectors in their backpack, you must also provide another set to keep in the health office for emergency use during the school day.*

4. **Regarding lunch, check only one option (questions 4 & 5 applicable only for grades 1-4)**
   ☐ **My child may purchase school-prepared lunch.** *Parents should review the Chartwells menu in advance of a student's purchase. Refer to the OHES or VES websites under "Lunch Menu" selection for more information. School and cafeteria staff will not make any determination of food safety as related to life-threatening allergies. Food allergen questions should be directed to Ms. Pat Kurczewski, Director of Dining Services, at 609-466-7602 ext 6510, or via email at chartwells@mtsd.us*

   ☐ **My child is not allowed to purchase school-prepared lunch; I will provide daily lunch from home.**

5. **During lunch, my child must* sit at: (check only one)**
   ☐ **No seating restriction** ☐ **Nut-free table** ☐ **Nut & liquid dairy-free table**
   *Students with a completed EAAP, current for the school year, are allowed to sit at the nut & dairy- free tables. The lunchroom aides are informed of students with life-threatening allergies & will monitor for compliance. *If 'No seating restriction' is checked, and your child has an EAAP, they may sit at one of the nut & dairy-free tables whenever desired. If you check one of the nut & liquid dairy-free tables, your child will be required to sit at that assigned table. Please contact your child's school nurse if you want to change your child's cafeteria seating during the year.*

6. **Does your child have asthma?** ☐ **Yes** ☐ **No**
   a. **If yes, will you provide an inhaler to keep at school?** ☐ **Yes*** ☐ **No**
   **As per: N.J.S.A. 18A:40-12.8, a health care provider completed NJ Asthma Treatment Plan is required if your child uses an inhaler during school, even if they are not diagnosed with asthma. See school nurse for this form.*

Parent/Guardian Signature: _____ Date: _____

The following to be completed by School Nurse:

IHP completed: ☐ Yes ☐ No IHP signed by parent: ☐ Yes ☐ No	Epinephrine received: ☐ Yes ☐ No EAAP received: ☐ Yes ☐ No	Genesis/Cafe note updated: ☐ Yes ☐ No Transportation notified: ☐ Yes ☐ No

Notes _____

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