Minors on Campus Program's Medical Form

SECTION I - TO BE COMPLETED BY PARENT(S)			
Child's Name		*Gender* ☐ Male ☐ Female	*Date of Birth*
Does Child Have Health Insurance? ☐ Yes ☐ No	*If yes, Name of Child's Health Insurance Carrier*		
Parent/Guardian Name	*Home Telephone Number*	*Work Telephone Number*	*Cell Phone Number*
Parent/Guardian Name	*Home Telephone Number*	*Work Telephone Number*	*Cell Phone Number*
Emergency Contact (other than parent)	*Home Telephone Number*	*Work Telephone Number*	*Cell Phone Number*
I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.			
Signature/Date		*This form may be released to WIC.* ☐ Yes ☐ No	

PERSONAL HEALTH ASSESSMENT: For the following questions, please check yes if you are presently having a problem or have had a problem in the past. If there is no significant problem, check no. Briefly explain all the answers.
TO BE COMPLETED BY PARENT;

Cardiovascular:	**Yes**	**No**	**Past Illness:**	**Yes**	**No**	**Mental Health:**	**Yes**	**No**
Heart Murmur/palpitations	☐	☐	Malaria, Hepatitis, Mononucleosis, Chicken pox and other childhood diseases	☐	☐	Any problem with your emotional health, requiring any form of therapy, including medication	☐	☐
Chest pain	☐	☐	Loss or absence of any body parts	☐	☐	Have you ever experienced a serious dietary problem (anorexia, bulimia, obesity)	☐	☐
Rheumatic fever	☐	☐	Severe/Frequent colds or flu	☐	☐			
High Blood pressure	☐	☐						
Irregular heartbeat	☐	☐	**Hospitalization:**	☐	☐	**Medications:**	☐	☐
Blood clots (not menstrual clots)	☐	☐	Have you ever been admitted to a hospital?	☐	☐	Do you take any medication (vitamins, over-the-counter-medications or prescriptions)?	☐	☐
Enlarged heart	☐	☐	Have you ever had surgery?	☐	☐	If yes, complete the **Student Medication Form**		
Respiratory:	☐	☐	**EENT:**	☐	☐	**Neurology:**	☐	☐
Asthma	☐	☐	Any problems with your eyes, ears, nose or throat	☐	☐	Seizure or convulsions	☐	☐
Chest infection	☐	☐	Hearing impairment	☐	☐	Fainting or blackouts	☐	☐
Shortness of breath	☐	☐	Loss of eye or eyesight	☐	☐	Dizziness	☐	☐
Wheezing	☐	☐						
Skin:	☐	☐	**Blood:**	☐	☐	**Gastrointestinal:**	☐	☐
Any problems with your skin?	☐	☐	Anemia	☐	☐	Problems with any part of your intestinal tract or stomach?	☐	☐
Skin rashes	☐	☐	Sickle-cell disease	☐	☐	Jaundice	☐	☐
			Abnormal bleeding or bruising	☐	☐	Hernia	☐	☐
Endocrine:	☐	☐	**Bone and Joint:**	☐	☐	**Allergy:**	☐	☐
Thyroid disease	☐	☐	Any serious disability deformity or disease of bone, joint, or muscle?	☐	☐	Any significant allergy to food, medications, insects, pollen?	☐	☐
Diabetes	☐	☐				Food?		
						Other?		
Urinary:	☐	☐	**Kidney Stones:**	☐	☐			
Impaired function of any part of your urinary tract or loss of a kidney	☐	☐						

I certify that the statement in Section I & II are true to the best of my knowledge, and I authorize NJIT to provide emergency treatment in the event of serious illness or injury. In case of a medical emergency, I understand that I will be notified as soon as possible by NJIT. Failure to contact me following reasonable efforts to do so, shall not prevent NJIT from administering or providing emergency treatment as may be necessary for the health or welfare of my child. I agree to hold NJIT, it's trustees, officers, employees, and agents harmless from any claims, liabilities or costs associated with providing medical care or treatment. I further agree that neither NJIT nor its trustees, officers, employees or agents shall be legally liable for any injuries, damages or other costs incurred by my child or by me or any family member on my child's behalf as a result of NJIT providing, securing or administering medical treatment or care of my child.

Parent Signature: _____ Date _____

Please see reverse side for Section II (Please have completed by doctor)

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:	Results of physical examination normal? ☐Yes ☐No

Abnormalities Noted:	Weight *(must be taken within 30 days for WIC)*	
	Height *(must be taken within 30 days for WIC)*	
	Head Circumference *(if <2 Years)*	
	Blood Pressure *(if >3 Years)*	

IMMUNIZATIONS	☐ Immunization Record Attached (**All immunizations must be up-to-date. Record must be legible**) ☐ Date Next Immunization Due:

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐ None ☐ Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	☐ None ☐ Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☐ None ☐ Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐ None ☐ Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☐ None ☐ Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☐ None ☐ Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☐ None ☐ Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: ☐Capillary ☐Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

I have examined the above student and reviewed his/her health history. The immunization record is reviewed and updated. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.

Name of Health Care Provider (Print)	Health Care Provider Stamp:
Signature/Date	