CITY OF NEW HAVEN
Health Department

NHVHEALTH
DEPARTMENT PROMOTE PREVENT PROTECT

54 Meadow Street, 9th Floor • New Haven, Connecticut 06519 • 203-946-6999

Justin Elicker, Mayor • Maritza Bond, MPH, Director of Health

Dear Parent/guardian,

Welcome to the new school year! The New Haven Health Department provides school health and nursing services to students in New Haven Public Schools. The Nurse at your child's school **must** have on file current health and emergency contact information to safely care for your child. **Also, please provide any medical alerts and/or conditions.**

PLEASE PRINT CLEARLY AND RETURN THIS FORM TO YOUR SCHOOL NURSE ON THE FIRST DAY OF SCHOOL

LAST NAME: _____FIRST NAME: _____ DATE OF BIRTH: ___/___/____

School Name: _____ Grade: _____ Homeroom:_____

PARENT/GUARDIAN INFORMATION:	
Name: _____ Relationship: _____	Name: _____ Relationship: _____
Home Phone: _____	Home Phone: _____
Cell Phone: _____	Cell Phone: _____
Place of Employment:_____	Place of Employment:_____
Work Phone: _____Ext.: _____	Work Phone: _____Ext.: _____

If PARENT/GUARDIAN CANNOT BE REACHED, CALL THE FOLLOWING EMERGENCY CONTACTS:
Contact Name: _____Phone: _____Relationship: _____
Contact Name: _____Phone: _____Relationship: _____

Please answer Yes or No with an **X** to the following questions:

Have there been any changes in your child's health history in the past year? Yes _____No _____

Does the child have any allergies (food, medications, environmental)? Yes ____No _____

If yes, please list: _____

Does the child have a diagnosed medical condition? Yes ____No _____ Please list: _____

Will the child require medication or special nursing care during the school day? Yes ____No _____

Student's Medical Provider: _____Phone #: _____

Does the child have health insurance? Yes _____No _____

If yes, please indicate type/name of insurer: _____

Please note information provided on this form may be shared confidentially with Health Department nursing staff, administrators and appropriate educational personnel when necessary.
Signature below allows permission to contact my child's health care provider(s) as listed on this form for confidential release and exchange of health information to meet my child's healthcare and educational needs.

Signature_____ Date_____