ALPHA PUBLIC SCHOOL

817 North Boulevard
Alpha, New Jersey 08865
Telephone: (908) 454-5000 Fax: (908) 454-4347
www.apsedu.org

Date: _____

To: Parents/Guardians

From: Meg Murray, School Nurse

Dear Parent/Guardian,

Welcome to another school year! Attached is a Health Record Update. **Please legibly fill out the attached forms and return them as soon as possible.**

I would like to share some information with you regarding our school health services program. This is a summary of some of the contacts your child will have with the school nurse this year:

- Screening for height, weight, and blood pressure shall be conducted annually for each pupil in kindergarten through grade 8.
- Screenings for visual acuity shall be conducted biennially for pupils in kindergarten through grade 8.
- Screening for auditory acuity shall be conducted annually for pupils in kindergarten through grade 3 and in grade 7 pursuant to N.J.S.A. 18A:404.
- Students in grades 5 and 7 will receive a spinal screening for scoliosis. Any student will be exempt from the scoliosis screening upon written request from a parent or guardian (NJSA 18A:40-4,3).
- All new students must be examined upon entry into the school district. This examination must be done no more than 365 days prior to entry and must state what, if any, modifications are required for full participation in the school program. The "Universal Child Health Record" form is available by contacting the school nurse.
- The nurse may administer prescribed medication. However, authorization is required from both the physician and the parent. The medication must be in its original container and must be brought to school by the parent/guardian. This policy also applies to over-the-counter or non-prescription medications. Please contact the school nurse for these forms.
- The REQUIRED district form(s) are available online or from the school nurse.

Please feel free to contact the school nurse at 908-454-5000 x205 with any questions you may have.

ALPHA PUBLIC SCHOOL
817 NORTH BLVD.
ALPHA, NEW JERSEY 08865
HEALTH OFFICE 908-454-4137

HEALTH GUIDELINES

During the school day, your children interact with many other children and adults. In order to maintain a healthy environment for all, please follow the guidelines below:

1. If your child has any of the following: fever of 100 or greater, vomiting, irritability, diarrhea, rash with fever or behavioral change, mouth sores with drooling, persistent cough and/or nasal discharge or symptoms that prevent your child from participating in school activities he/she should remain home until symptom free for 24 hours or a physician has determined the child is able to return.

2. If your child has a generalized illness (see above) during the school day, he/she will be excluded and should remain home until symptom free for 24 hours or until a physician has determined the child is able to return.

3. If your child has strep throat, he/she is excluded for 24 hours after medication with antibiotics has begun.

4. If your child has pink eye (purulent conjunctivitis), he/she will be excluded until examined by a physician and approved for readmission with no purulent (pus) discharge.

5. All cuts and abrasions should be kept clean and covered with a bandage. Any unusual amounts of drainage or swelling will be referred to the child's medical provider. If your child has impetigo and/or a draining wound that cannot be covered sufficiently, he/she is excluded until appropriately treated.

6. A child will also be excluded for communicable diseases in accordance with New Jersey Law/American Academy of Pediatrics Red Book.

7. If your child has any serious injuries, surgery or is hospitalized a note from the doctor is needed to return to school. The note should indicate if there are any limitations or if your child is allowed to participate in all school activities. **The school physician has the final review of any reports and orders from a child's medical provider.**

8. The spread of any infectious disease can be prevented or deterred if students adhere to basic principle of good personal hygiene, cleanliness and recommended use of personal protective measures.

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PHYSICAL EXAMINATION

New Jersey State Board of Education and the New Jersey Department of Health and Senior Services require that each student: is not diminished by a remediable physical disability, that the student is able to participate in the school program, and that the school community is protected from the spread of communicable disease.

The physical examination must be done no more than 365 days prior to the entry of school. If any modifications are required for full participation please provide the school with the proper documentation.

A healthcare provider chosen by the student's parent/guardian, also referred to, as the students' MEDICAL HOME, must conduct the medical examination. A full report must be presented to the school on approved school district form. Please be sure that your physician signs and dates the form.

If the student does not have a "medical home" please contact the school nurse or school secretary for more information.

Rev. 11/02 Physical Examinations

Student Health History & Emergency Medical Treatment Consent Form

School Year _____

Student		**School**	**Grade/Teacher**
Address		**Birth Date**	**Gender**
Parent/Guardian/Emergency Contacts	**Relationship**	**☎ Phone**	
Call 1st:		Home: Cell:	
		Work:	
Call 2nd:		Home: Cell:	
		Work:	
Call 3rd:		Home: Cell:	
		Work:	

Student's doctor/healthcare provider: _____ **Phone:** _____

Insurance Information: _____

(Include Group's Name, ID Number, Group Number, and Subscriber)

INDICATE IF STUDENT HAS BEEN DIAGNOSED BY A LICENSED HEALTHCARE PROVIDER WITH ANY OF THE FOLLOWING:

If your child has a life-threatening condition, state law requires that medication and/or treatment orders from your licensed healthcare provider, and an Emergency Plan prepared by the School Nurse, must be in place before your child can attend school.

Health Condition	Yes	No	Explanation if "Yes"
Medication Allergies	☐	☐	List:
Food Allergies	☐	☐	Food(s): ☐ peanut ☐ dairy ☐eggs ☐other _____ Rate the reaction: ☐mild ☐moderate ☐ life-threatening Does your child require an EpiPen? ☐yes ☐no
Allergy to Bees Stings	☐	☐	Rate the reaction: ☐mild ☐moderate ☐ life-threatening Does your child require an EpiPen? ☐yes ☐no
Allergies (other)	☐	☐	List:
Asthma	☐	☐	Rate the severity: ☐mild ☐moderate ☐ life-threatening Asthma medication taken at home: Medication required at school:
Diabetes	☐	☐	☐Type 1 (Insulin Dependent) ☐Type 2 Diabetes medication(s) taken at home:
Seizure Disorder	☐	☐	Type of Seizure: Medications: _____
Neurological Disorder	☐	☐	Specify:
Heart Condition	☐	☐	Specify:
Blood Disorder	☐	☐	Specify: Treatment:
Cancer	☐	☐	Specify: Treatment:
Bowel/Bladder Issues	☐	☐	Specify:
Migraine Headaches	☐	☐	Triggers: Treatment:
Bone/Muscle Problems	☐	☐	Specify: Activity Restrictions:
ADD/ADHD	☐	☐	Medication for ADD/ADHD:
Mental Health Behavioral Issues	☐	☐	Specify: Treatment/Medication:
Wears Glasses/Contacts	☐	☐	☐Glasses ☐Contacts → ☐For Distance ☐For Reading
Hearing Loss	☐	☐	☐Hearing Loss Right Ear ☐Hearing Loss Left Ear ☐Hearing Aid(s)
Other Serious Illness	☐	☐	Specify: Date of Onset:
Serious Injury	☐	☐	Specify: Date(s):
Surgery	☐	☐	Specify: Date(s):
Medication Taken at Home ***(if not already listed)***	List:		

The information on this form may be shared confidentially with school staff and emergency responders as needed. In the event of a medical emergency with my child, I understand every effort will be made to inform me. If emergency care is needed, I authorize qualified professionals to provide assessment, diagnosis and any necessary emergency treatment. I understand that the school district assumes no financial liability for expenses incurred due to accident, injury and/or unforeseen circumstance.

_____ _____ _____

PARENT/GUARDIAN SIGNATURE *PRINTED NAME* *DATE*

Rev. 4/2009 *Reviewed by School Nurse:*

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SCOLIOSIS SCREENINGS ARE REQUIRED OF ALL 5TH AND 7TH GRADE STUDENTS.

- I do wish to have my child included in the scoliosis screening program.
  Yes _____ No _____

- I will have my 5th or 7th grade child examined by our family physician **AND SUBMIT THE REPORT TO THE SCHOOL NURSE**.
  Yes _____ No _____

PERMISSION FOR RELEASE OF HEALTH INFORMATION

This release authorizes the school nurse to send or receive pertinent medical information necessary for my child's health, well-being and safety. This authorization is valid for one year.

Student's Name: _____

Date of Birth: _____

Grade/Teacher: _____

Parent/Guardian's Name (MUST PRINT): _____

Parent/Guardian's Signature: _____

Date: _____