ALPHA PUBLIC SCHOOL

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www.apsedu.org

Mr. Seth Cohen
Chief School Administrator

August 2024

To: Parents/Guardians

From: Laura Griffiths, BSN, RN,CSN-NJ School Nurse

Dear Parent/Guardian,

Welcome to another school year! Attached is a Health History & Emergency Treatment Form. **Please legibly fill it out and return it to my attention 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.
- Screening 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 NJSA 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:4-4,3).
- 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 through the school website.
- 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 from the school nurse or at the school website www.apsedu.org.

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

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 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 Examination

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: _____

Student Health History & Emergency Medical Treatment Consent Form **School Year 202 - 202**

Student:	**School: Alpha**	**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 #, Group # & 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:
Allergies (other)			List:
Food Allergies			Food(s): Rate the Reaction: Mild Moderate Life-Threatening Does your child have an EpiPen? Yes No
Allergy to Bee Stings			Rate the Reaction: Mild Moderate Life-Threatening Does your child have an EpiPen? Yes No
Asthma			Rate the Severity : Mild Moderate Life-Threatening Asthma medication taken at home: Medication required at school:
Diabetes			Type 1 (Insulin Dependent) Type 2 Medication Required at School:
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 Aides
Other Serious Illness			Specify: Dates 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 confidentiality with school staff and emergency responders as needed. In the event of 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

Reviewed by School Nurse:_____