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

Mr. Seth Cohen
Chief School Administrator

Mrs. Lori Walker
Supervisor of Instruction

Dear Parents/Guardians of students starting Alpha Public School,

As required by NJ law, N.J.A.C. 8:57-4.2, all students entering Alpha Public School must have documentation of their current immunizations and current health physical to begin the school year. Please complete the enclosed Student Health History/Emergency Medical Treatment Consent form and Universal Child Health Record form completed by your doctor. The health form must also note any allergies, vision or hearing difficulties, or any significant medical conditions.

The following immunizations are required for admittance:

- DTaP - a total of 4 doses with one of these doses on or after your child's 4th birthday or any 5 doses.
- Polio (IPV) a total of 3 doses with one of these doses given on or after your child's 4th birthday or any 4 doses.
- HIB series at least one dose given after 1st birthday
- Pneumococcal conjugate (PCV 13) at least one dose given after on or after 1st birthday
- MMR - 2 doses
- Varicella - 1 dose
- Hepatitis B -3 doses
- Influenza (Pre-K and Kindergarten) one dose each year between 9/1-12/31 (*documentation must be received by 12/31 in order for the student to remain in the Pre-school program*)

All new families must complete and submit all required forms and documents for each child entering the district. Registration will be considered pending until all required documentation has been verified.

If the student has a religious exemption, please forward a signed document by a parent or guardian stating this. If there is a medical exemption, please show the necessary documentation from your physician.

Any documentation may be sent to Alpha School District addressed to the school nurse. If you have any questions, please call me at (908) 454-5000 ext 205.

Thank you for your time and cooperation. Stay safe and healthy!

Laura Griffiths, RN, BSN

School Nurse, Alpha Public School

APPENDIX H

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: *American Academy of Pediatrics, New Jersey Chapter*
New Jersey Academy of Family Physicians
New Jersey Department of Health

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name *(Last)*	*(First)*	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/Cell Phone Number ( ) -	
Parent/Guardian Name	Home Telephone Number ( ) -	Work Telephone/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

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 ☐ 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. 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	

Student Health History & Emergency Medical Treatment Consent Form

Student:	School: Alpha	Grade/Teacher:
Address:	Birth Date:	Gender:

Parent/Guardian Emergency Contacts:	Relationship:	Phone:
Call 1st:		Home: Cell:
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:_____