Alpha Public School

817 North Blvd. Alpha, NJ 08865

Telephone: 908-454-5000

Mr. Seth Cohen

Chief School Administrator

Fax: 908-454-4347 Mrs. Lori Walker

Assistant Principal / Supervisor of Instruction

Welcome to Alpha, New Jersey. Students that reside in Alpha that will be attending Phillipsburg High School must first make an appointment with Alpha Public School to register the student. Please call us at (908) 454-5000. We will need **three** proofs of residency.

We requite **one** document from each category below:

Category A -

 Driver's License or Non-Driver Photo Identification Card from NJ Division of Motor Vehicles with your current address. We will accept a copy of the online change of address form/appointment for new license.

Category B -

- The most recent real estate tax bill for your residence showing you as the taxpayer.
- A signed lease or deed for your residence.
- A closing statement for the purchase of residence.
- A Notarized affidavit from you and the owner of the residence stating that you reside at the residence on a full-time basis. Affidavits are available in the office or on our website.

Category C -

- Gas, electric or water bill dated within 3 months.
- Home/Apartment Insurance Certificate.
- First Class mail/letter from state or federal agency dated within 3 months.
- Bank statement dated within the past 60 days.

Category D -

• Competed Transportation from Alpha Public School.

In order for your child to be enrolled in the Phillipsburg High School you must complete their Registration Packet (can also be found at www.pburgsd.net). Once completed please call the Central Registration Office, located at 50 Sargent Avenue, (908-454-3400 X1000) to schedule an appointment. Once enrolled you will receive a call from busing letting you know your bus stop as well as time.

If you experience any difficulties with the enrollment process, please contact Staci Horne at (908) 454-1100 for assistance,

ALPHA PUBLIC SCHOOL

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

TO: Guidance Dept.

Phillipsburg High School Phillipsburg, NJ 08865

This is to certify that the following student is registered with the Alpha Board of Education and may be accepted as a tuition student at Phillipsburg High School. If you determine that any of this information is inaccurate or should be changed during the course of the student's tenure at Phillipsburg High School, please notify our Main Office so that our records remain consistent with yours.

Satisfactory evidence of this student's eligibility includes the following:

New Student: Transfer Student:	Change of Ad Transferred F	ldress: rom:	Moved:	
Student Name:				Grade:
La	ast	First	Middle	
Parent/Guardian Name): 			
Current Address:				
Last Address:				
Telephone Number:				
Date of Birth:				
Authorized By:				
Printed Name/Title: _				
Date:				



Welcome To.... Phillipsburg School District Central Registration Sending District

In order to proceed with the registration process for your child to enroll, please complete the enclosed registration packet and medical information. When you have completed all of the necessary information, please call the Central Registration Office, located at 50 Sargent Avenue, (908-454-3400 x 1000) to schedule an appointment.

SENDING DISTRICT STUDENTS

Students that reside in *Alpha, Bloomsbury, Greenwich, Lopatcong, and Pohatcong* send students in Grades 9-12 to Phillipsburg High School. Residents of these districts must first notify the district where they reside, and also complete the **Sending District Registration Packet**. Please review the documents needed below and remember to bring them with you at the time of your appointment.

DOCUMENTS NEEDED:

	Completed Registration Packet
	Medical Information Packet & Immunization Records
	Birth Certificate (If name has been changed, must provide proof of name change)
_	Sending District Letter of Residency
	Individualized Education Plan (if receiving special education services)

If you experience difficulties with the enrollment process, please contact Staci Horne at 908-454-3400 x 1100 for assistance.

Phone: 908-454-3400 <u>www.pburgsd.net</u> Fax: 908-213-2424



PHILLIPSBURG SCHOOL DISTRICT

50 Sargent Avenue Phillipsburg, NJ 08865
Telephone: 908-454-3400 Ext. 1000 Fax: 908-213-2424

SENDING DISTRICT REGISTRATION FORM

STUDENT INFORMATION (Please Print & Complete "Each" Page!)			' Pagel)	!	DATE:			***********
Full Legal Name: (Las	t, First, Middle)		water water and the same and th					
Address: (Number, Str	eet, City, State, Zip)			W. W			······································	•
Home Telephone		Date of Birth ((M/D/Y)	P	lace of Birth	/ (City /	/ State / Country)	
Grade Level	Year of HS Grade	uation Gende	er (M / F)		Se	ending Di	istrict	
Name of Previous Scho	ool	Addr	ress		C	ity / Stat	e / Zip	
Has this student ever a			trict? If yes, ☑ No	when?				
<i>Please circle</i> (Ethn Student's <u>Primary</u> Lar	ack/African American icity: Hispanic – Y nguage:	es / No) 3a) L	American II -anguage <u>fi</u> rimary Lang	guage Spoker	oy Student: _ n at <u>Home</u> : _		Hawaiian/Other P	
If student was NOT b			ne date of U	-	4 hall bedoor general whole	-		
Parent/Guardian(s) Wit	h Whom Student Resid	des			Re	ationship	to Student	
All Other Members of	Household	Relationship to \$	Student	Sch	nool Attendin	g	Grade in Sch	ool
								-
OFFICE USE ONLY:	☐ Birth Certificate	□ Immunizations	□ IEP	☐ Custody	☐ Tuition	Letter	☐ School Recor	ds
/ F-4 P-4		Cab a al		ID St.	1			
Entry Date		School	_	ID Num	inel.		Grade	
□ Scanned	☐ Emailed		Regi	strar's Initials_				

Residency Status Confirmed Via Sending District Records.

Mailing Address: Cell Phone:	PRIMARY PARENT/C	UARDIAN
Mailing Address: Cell Phone:	Name:	
Cell Phone: Email:	Relationship to Child:	☐ Mother ☐ Father ☐ Other:
Cell Phone:	Mailing Address:	
SPOUSE/SIGNIFICANT OTHER Name:		
SPOUSE/SIGNIFICANT OTHER Name: Relationship to Child:	Work Phone:	
Relationship to Child:	SPOUSE/SIGNIFICAN	
Mailing Address: Cell Phone: Provider:	Name:	
Cell Phone: Provider: Email:	Relationship to Child:	☐ Mother ☐ Father ☐ Other:
Cell Phone: Provider: Email:	Mailing Address:	
Check appropriate boxes if may receive: Attendance Schedules Report Cards Discipline General Info Check appropriate boxes if student may: See Go with Speak to Does not have contact with SECONDARY PARENT/GUARDIAN		
Check appropriate boxes if student may:	Work Phone:	Email:
Name:	Check appropriate boxes if may re Check appropriate boxes if studen	ceive:
Name: Relationship to Child:	CECOND I DV D I DEN	
Relationship to Child:		
Mailing Address: Cell Phone: Provider: Work Phone: Email: Check appropriate boxes if may receive: Attendance Schedules Report Cards Discipline General Info Check appropriate boxes if student may: See Go with Speak to Does not have contact with EMERGENCY CONTACT Name:		
Cell Phone: Provider:	•	
Work Phone: Email: Check appropriate boxes if may receive: Attendance Schedules Report Cards Discipline General Info Check appropriate boxes if student may: See Go with Speak to Does not have contact with EMERGENCY CONTACT Name:		
Check appropriate boxes if may receive: Attendance Schedules Report Cards Discipline General Info Check appropriate boxes if student may: See Go with Speak to Does not have contact with EMERGENCY CONTACT Name:		
Check appropriate boxes if student may:	Work Phone:	Email:
Name:		
	EMERGENCY CONTA	ACT
Delationshin: Dhone:	Name:	
Kelationship. Filone.	Relationship:	Phone:

PLEASE ANSWER THE FOLLOWING. If you answer yes to any of the	ese questions, please complete the information	n <u>below</u> the question.
1. Is there a custody/guardianship agreement? (Copy must be prov	ded)	□No
Parent/Guardian of Record		
2. Is this student currently receiving special education services? Co	ppy of IEP must be provided Yes	□No
Date of Classification Case Manager		Telephone
If no, has student ever received special education services?	□Yes	□No
3. Has this student ever qualified under Section 504 of the Rehabilit	ation Act?	□No
4. Is student in foster care or in a court placement?	□Yes	□No
Name of Agency Caseworker	Telephone Date of Pla	cement
Name of Agency Caseworker PARENT(S)/GUARDIAN: Please check (√) appropriate box:	Telephone Date of Pla	cement
	Telephone Date of Pla	cement
PARENT(S)/GUARDIAN: Please check (√) appropriate box:	Telephone Date of Pla	cement
PARENT(S)/GUARDIAN: Please check (√) appropriate box: Military Connected:	, and the second	
PARENT(S)/GUARDIAN: Please check (√) appropriate box: Military Connected: □ Not Military Connected – Student is not military connected	Fime: Army, Navy, Air Force, Marine Corps or Co	
PARENT(S)/GUARDIAN: Please check (√) appropriate box: Military Connected: □ Not Military Connected – Student is not military connected □ Active Duty – dependent of a member of the Active Duty Forces (Full	Fime: Army, Navy, Air Force, Marine Corps or Co	
PARENT(S)/GUARDIAN: Please check (√) appropriate box: Military Connected: □ Not Military Connected – Student is not military connected □ Active Duty – dependent of a member of the Active Duty Forces (Full	Fime: Army, Navy, Air Force, Marine Corps or Co ne National Guard or Reserve Forces	ast Guard)

Phillipsburg School District School: Phillipsburg High School Fax #: 908-777-3978 Address: 1 Stateliner Boulevard _____, Phillipsburg NJ 08865 **Request for Records Previous School District:** Contact Name: Fax #: has recently enrolled in Grade in the Phillipsburg School District and has named your school as the one he/she last attended. Please send us the information listed below, so that we may make the proper placement. Report Cards / Cumulative Scholastic Records • Discipline Records • Social / Medical / Health Records Attendance Records **Test Results** Child Study Teams Scores / I.E.P. NJ Smart ID Number ☐ This student is registered as a tuition student. As the district of residence, a tuition contract will be sent upon completion of registration. This student is registered as McKinney Vento as per NJAC 6A:17-2.9(a). If you have any questions/comments regarding this registration, please call us at 908-213-2651. Thank you. **Authorization for Release of Information** I, the undersigned parent or legal guardian of the above named student, authorizes the Phillipsburg School District to obtain from any person/agency any and all information concerning this child, including health and academic records. I further understand that any Child Study Team materials will be forwarded to the Phillipsburg Child Study Team. Relationship Date____ Signed___



ELL IDENTIFICATION FORM

STU	DENT NAME:	GRADE:
1	What was the first language used by student?	
2.	At home, does the student hear or use a language other than Engl the time? YES or NO. If YES, list language(s):	
3.	Does the student understand a language other than English? YES or NO. If YES, list language(s):	
4.	When interacting with his/her parents or guardians, does the stude other than English more than half of the time? YES or NO If YES, list Language(s):	
5.	List home language(s) spoken:	
6.	When interacting with caregivers other than his/her parents or guastudent use a language other than English more than half of the tin If YES, list language:	ne? YES or NO
7.	Has the student recently moved from another school district where identified as an English language learner? YES or NO	e he/she was

Phillipsburg School District Parent Access Authorization Form

(PHS: Please return to the Guidance Office.)

PLEASE PRINT ALL REQUIRED INFORMATION NEATLY AND LEGIBLY

Student's Last Name:	~~~				
Student's First Name:					
School Attending (please circle):	PHS	PMS	PES	PPS	ECLC
Current Grade:					
Name of Parent Requesting Access:					
(please circle):	Custodial	Parent	N	on-Custodial Pa	rent
<u>Email address</u> (required)*:_					
Language preferred in Parent Modu	<u>ıle</u> (please c	ircle): En	glish S _l	oanish	
Mobile Provider Used (plea	se circle): A	litel / AT&T W	ireless / Boost	Mobile / Cingul	ar / Cricket /
Metro PCS / Nextel / Project	-			· -	•
USA / Unknown / Other:			TO A DESCRIPTION OF THE PARTY O		
*Confirmation of registration	on will be se	ent to the <u>abov</u>	<u>e email addre</u>	ss when activa	ted.
Are there any siblings in our schoo	l district the	it should be lin	ked to this ac		
Student's Name:				School/Gr	rade:/
Student's Name:				School/Gr	rade:/
Student's Name:		******************************		School/Gr	ade:/
		Office Use Or	nlv:		
Proof / Driver's License Submitted	· v n /		-	/ /	Bv.



Parent Occupational Survey

In order to better serve your child, our school district wants to identify students who may qualify to receive additional educational services, such as tutoring, school supplies, free or reduced-price lunch, summer camps, and other services. The information provided below will be kept confidential. Please answer the following questions and return this form to yourchild's school.

Today's Date		Parent/Guardian First & Last Name
Student First Name		Student Last Name
School Name		Student Grade
1. Have you or an immediate family of the United States, in the past three y	nember performed any of the jobs listed bel ears?	ow temporarily or seasonally,in any part of
□ No		
☐ Yes. Check all that apply and	list the total number of months worked	d:
	to the track	
☐ Agriculture/Field Work (planting,	☐ Processing & Packaging (fruit,	
picking, sorting crops; soil preparation;	vegetables, chicken, eggs, pork, beef)	☐ Dairy/Cattle Raising
irrigation; fumigation)	3 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	(feeding, milking, rounding up)
Total Months Worked:	Total Months Worked:	Total Months Worked:
		A Section 1
	- Forestwa (soil manageting planting	☐ Commercial Fishing & Processing
☐ Nursery/Greenhouse (planting, potting, pruning, watering, harvesting)	 □ Forestry (soil preparation, planting, cutting trees; landscaping not included) 	(catching, sorting, packing, transporting)
Total Months Worked:	Total Months Worked:	Total Months Worked:
2. In the past three years, has you	r family moved to another state, city, sc	hool district, and/or county?
□ No		
Yes. How long have you resid		
Years	Months	Weeks
f you answered "Yes" to question	s 1 and 2, please complete the informat	ion below.
Home Street Address		Apt#
		Αρι #
City	State	Zip Code
elephone Number	Best Day of Week & Time	of Day to Call
or School Use Only: Please send survey wit	h two YES responses to your district migrant liaison.	
tudent State ID:	Incollment Date:	I Novelland
radent State ID.	Enrollment Date:	District ID:



Phillipsburg School District

50 Sargent Avenue, Phillipsburg, New Jersey 08865

Medical Information Checklist

School Health Program Information (keep for reference)	1 page
New Student Proof of Physical Exam Requirement Letter (complete and return lower portion)	1 page
Authorization for Obtaining and Sharing Student Health Information (complete Section 1 and return; Section 2 to be completed if further specific information is needed)	1 page
Student Health History and Emergency Contact New/ Update Form (complete and return)	2 pages
☐ In School Medication Administration Authorization (physician to complete if needed and parent to return to school nurse)	1 page
Physician Exam Form Doctor to complete and parent to return. Form depends on Grade level.	
a. Elementary School – Pre-school through 5th grade	
Universal Child Health Record	2 pages
<u>OR</u> b. <u>Middle School/High School</u> – 6 th through 12 th grades	
☐ HEALTH HISTORY (PART A NJDOE/AAPEF 10/07)	3 pages
Must be filled out by parent/student and presented to physician	- FB.
at exam	
☐ PHYSICAL EXAM (PART B NJDOE/AAPEF 10/07)	3 pages
Must be filled out by examining licensed provider at time of exam	_
☐ Note to examining physician	1 page
☐ Athletic Letter- School Sports Information (keep for reference)	1 page

IMMUNIZATION (SHOT) RECORDS MUST BE APPROVED BY THE SCHOOL NURSE PRIOR TO THE ADMISSION OF EACH STUDENT INTO SCHOOL.



Phillipsburg School District

50 Sargent Avenue, Phillipsburg, New Jersey 08865

Dear Parents:

(Please keep this page for reference)

The school health program in Phillipsburg School District is designed to maintain the physical and emotional well being of all students. To attain this goal, many services are routinely available to all students of the district. However, as with any school program, we are only effective if full cooperation is received from both students and parents. The following procedures and services are currently in effect:

MEDICATION: Medication can be administered in school ONLY when the nurse has written instructions from the student's physician, including the students name, name of the drug being administered, directions to administer the drug, and the reason the drug has been prescribed for the student. These instructions (doctors' orders) must be renewed every year. Parents must also sign a permission slip for the nurse to administer prescribed medication. THIS LAW ALSO APPLIES TO ALL OVER THE COUNTER MEDICATIONS, SUCH AS ASPIRIN, TYLENOL, OR ALLERGY MEDICATIONS. The exception is over the counter eye solutions necessary for daily contact wear, and cough drops individually carried, if identifiable by manufacturer's label.

LEAVING SCHOOL BECAUSE OF ACCIDENT OR ILLNESS: When it becomes necessary for a student to leave school due to accident or illness, a parent/guardian, or their designee, must come to school and sign the student out in the main office. Please be sure to return the emergency permission form to school indicating person/persons authorized to pick up your child. Leaving from the health room does not constitute an excused absence from school.

GYM EXCUSES: Students are required to participate in physical education classes unless they have a current doctor's excuse. Please be sure the doctor includes the amount of time that the student will be unable to participate in gym (for example, one week or one month) or any restrictions, including sports, the student may have.

IMMUNIZATIONS: A constant monitoring of the student's immunization status is conducted throughout the year in keeping with New Jersey requirements. If immunizations become due, parents will be notified by letter. The needed immunization must be received within the allotted time span.

HEALTH SCREENINGS BY SCHOOL NURSE: The nurses conduct several health screenings throughout the year. Height, weight, blood pressure, pulse, vision, hearing, and scoliosis screenings are done for selected grades during the year. Parents will be notified if the screenings indicate a need for medical attention.

SCOLIOSIS (Curvature of the spine): New Jersey Law requires all students aged 10 to 18 years old to be examined for scoliosis every other year beginning in 5th grade. Parents will be notified by letter if further evaluation is needed. If you do not want your child examined for any reason, please notify the school in writing within 30 days of receiving this notice.

PHYSICAL EXAMINATION:

- New student physicals, working paper physicals, and sports physicals should be preformed by the students own physician (Medical Home Office).
- In addition to above requirements the State of New Jersey recommends a physical for each student at least once during each of the students developmental stages:
 - o Early Childhood (Pre-school through grade 3)
 - o Pre-adolescence (Grade 4 through grade 6)
 - o Adolescence (Grade 7 through grade 12)
- If your child has had a physical during the year, please send a copy and any immunization updates to the nurses office so that we can document the information on their school health records.

PLEASE COMPLETE THE ENCLOSED EMERGENCY PERMISSION FORM AND STUDENT HEALTH UPDATE. RETURN THEM TO THE NURSING OFFICE IN YOUR CHILDS SCHOOL. PLEASE INCLUDE ANY INFORMATION WE MAY NEED TO MAINTAIN A CURRENT CONFIDENTIAL RECORD.

REV. 6/2017

PHILLIPSBURG SCHOOL DISTRICT

Dear Parent/Guardian:

The New Jersey Department of Education requires every new student entering the Phillipsburg School District to have a report of a physical exam signed by the doctor submitted to the school nurse within 30 days of entering school. The exam must have taken place within the past calendar year. The school district has the right to exclude any student who has not returned the signed physical report 30 days after school entry.

IMMUNIZATION RECORDS must be evaluated and verified by the School Nurse prior to your child starting school in the Phillipsburg School District. Under NJAC 6A:16 2.2 (b) it states. Each school district shall ensure that a principal or his or her designee does not knowingly admit or retain in the school building any student whose parent has not submitted acceptable evidence of the child's immunizations, according to the schedule specified in NJAC 8:57-4, Immunizations of Pupils in School.

Your cooperation is appreciated,

Gregory Troxell

Gregory Troxell Superintendent

N.J.A.C 6A:16-2.2 & N.J.S.A. 18A: 40-4

Please sign and date and return lower portion to your child's school nurse. Thank you.

I have received and read the above notice and that I understand that proof that a physical exam that
has taken place within the past calendar year must be returned to the school nurse within 30 days of
school entry. I understand that my child cannot attend school without proof of his/her immunizations

Student Name:	Date of Birth:			
Parent/Guardian Signature:	Date:			



Phillipsburg School District

50 Sargent Avenue, Phillipsburg, New Jersey 08865

Authorization for Obtaining and Sharing Student Health Information.

There are laws that protect the privacy of student health information. At times the school will need to obtain records from your doctor or other health professional. This may include but is not limited to: Immunization Records, Medication Orders, Medical Excuses and Releases, Reports of Medical Examinations. Health information will be restricted to appropriate staff members directly involved in your child's care to avoid any health related problem on a need to know basis. This may include but is not limited to: information related to allergies, medications and serious medical conditions such as asthma, diabetes, seizures.

Student Name:	Date of Birth
Section 1: Authorization for shari	ing of health information with appropriate
school staff: (complete for all stud	ents)
Parent/Guardian Signature	Date
Section 2: Authorization for releas	se of medical records from doctor or
institution (complete for all studen	nts)
Parent/Guardian Signature	Date
Section 3: Information Requested	by School Nurse/School Physician (only
complete when further specific inf	
Records to be obtained from:	
Name of Doctor/Practice/Institution	
Address:	
Records to be returned to:	
☐ Early Childhood Learning Center	459 Center Street, Phillipsburg, NJ 08865
Phillipsburg Primary School	1000 Green Street, Phillipsburg, NJ 08865
☐ Phillipsburg Elementary School	525 Warren Street, Phillipsburg, NJ 08865
Phillipsburg Middle School	200 Hillcrest Boulevard, Phillipsburg, NJ 08865
Phillipsburg High School 1 Stateliner Boulevard Phillipsburg NI 08865	



Phillipsburg School District 50 Sargent Avenue, Phillipsburg, New Jersey 08865

Student Health History and Emergency Contact Form

Identification:		
Student Name:	Date of Birth	Grade
Address:	Home Phone #	
Family and Emergency Contact:		
Father Namework #_	cell #	<u> </u>
Mother Namework #_	cell #	<u></u>
Emergency Contacts: must be able to reach school i	n 30 minutes or less	
1. Name	Relationship_	
Home #Work #	Cell #	77874777877777777777777777777777777777
2. Name	Relationship_	
Home #Work #	Cell #	
Doctor Name	Phone #	
Dentist Name	Phone #	•
Authorization for Emergency Treatment in S. In case of accident or serious illness when I cannot be treatment and procedures as deemed necessary by the information with staff on a need to know basis. Hospital of Choice for Emergency	e contacted, I grant per physician AND shari	mission for emergency ng of any medical
Hospital of Choice for EmergencyPrin	ted Name	Date
Does your child have Health Insurance? ☐ Yes, Name of insurance company		
No: NJ Family Care provides free or low cost he certain low income parents. For more information, plwww.njfamilycare.org to apply online. My name and Care Program to contact me about health insurance. Signature:	ease call 800-701-0710	or visit



Phillipsburg School District 50 Sargent Avenue, Phillipsburg, New Jersey 08865

IDENTIFICATION:			
Student Name:	Date of Birth	_Grade:	
Immunizations:			
Please submit any new/ updated record no	t already on file with the school	nurse.	
Allergies and Dietary Restrictions	: Explain all "yes" answers b	elow	
Food		Yes	No
If yes, Must have yearly updated "Allergy Acti	on Plan" filed with nurse		
Medication		Yes	No
Bee Sting		Yes	No
Describe reaction (example: rash, difficulty b	reatning, anaphylaxis		
Medications Taken Regularly:		Yes	_ No
If medication is to be given in school,			
Must have yearly updated "In School Medicate List Medications and Reason for Use	on Authorization" filed with nurs	e	
General Medical Information Expl	ain all "ves" answers below		
Hospitalizations:	J = 2 2240 11 0 2 0 0 0 0 10 11	Yes	No
Operations:		Yes	No
Major Injuries, Broken/Fracture Bones:		Yes	No
Explain with date and age			
Serious Health Conditions Explain	all "yes" answers below:	······································	-
Asthma		Yes	No
Exercise induced asthma		Yes	No
Diabetes		Yes	No
Heart problems/ High blood pressure		Yes	No
Kidney/Bladder problems		Yes	No
Vision/Hearing problems		Yes	No
Seizures/Epilepsy		Yes	No
Muscle/ Bone problems		Yes	No
scoliosis last doctor screening date	***************************************		
ADHD/ Mental health problems		Yes	No
For preschool/elementary school behave		Yes	No
Speech difficulty Slow learner	Bowel/bladder accidents		
Temper tantrums Overactive In			
Fears: noises crowds school ar	<u>U</u>		
Have there been any events in your child	's life that may affect learning?	Yes	No
(example death, divorce)			
Family Social/Health History:			
Does anyone smoke in the house		Yes	No
Please list names and ages of household memb			
Please explain any family health history that yo	an would like to notity us of		

PHILLIPSBURG SCHOOL DISTRICT IN SCHOOL MEDICATION AUTHORIZATION

Main Number: (908)454-3400

Early Childhood Center Ext. 3020 (Fax: 908-213-2821)

Phillipsburg Primary School Ext. 4020 (Fax: 908-213-2552) Phillipsburg Elementary School Ext. 5020 (Fax: 908-213-2546) Phillipsburg Middle School Ext. 6020 (Fax: 908-213-2427) Phillipsburg High School Ext. 7020 (Fax: 908-213-2427)

New Jersey state law requires a written statement from a physician when a student needs to take a prescription or over the counter medication during school hours. *Medication orders are only effective for the current school year.* Medications must be in the original prescription container labeled by the pharmacy or in the original over the counter container.

MEDICATION CANNOT BE DISPENSED IN SCHOOL UNTIL A WRITTEN ORDER IS RECEIVED FROM YOUR CHILD'S PHYSICIAN.

Policy Regarding Self-Administration of Medication

Only those students who have asthma and other potentially life threatening illnesses are permitted to carry and selfadminister inhaled or injectable medication for the treatment/prevention of symptoms. They must be sufficiently responsible and properly educated by their physician and parent/guardian.

After self-medicating with an inhaler for symptomatic wheezing/shortness of breath, the student is strongly encouraged to report to the School Nurse to have an assessment to determine effectiveness of the medication.

Students self-medicating with an Epi-Pen must report to the School Nurse.

Students with food allergies must submit a separate Allergy Action Plan from their physician.

	-			
Student's Name:	Diagnosis:	Grade:	DOB:	
Parent/Guardian:	Home Phone:	Work Phone:		

MEDICATION	DOSAGE / ROUTE	FREQUENCY/ INDICATION	SIDE EFFECTS
:			
Student i	may carry medication: YES NO	Student may self-administer medication: Y	'ES NO

Asthma Action Plan and Emergency Asthma Policy

On ½ days: As ordered

Omit

Adjust Schedule

A separate Asthma Action Plan should only be submitted if the physician does not agree.

• If a student presents with wheezing/shortness of breath, prescribed medication will be given.

Adjust Schedule

- Students showing marked improvement after 10 min. post-treatment observation will be permitted to return to
- If a student DOES NOT show marked improvement after one dose of medication, parent will be called to pick up student and seek physician care.
- Up to two (2) additional treatments will be given at 20 minute intervals while awaiting arrival of parent.
- If condition worsens, 911 will be called.

Omit

On class trips: As ordered

Physician's Signature	Physician Phone #	Date	•
As the parent / guardian of this studen indemnify and hold harmless the Philli	t, I request he or she be allowed to receive the mo psburg School District, it's agents and employees	edication prescribed above. I hereby agree	e to
as a result of the administration of the			

Revised 8/16

■ PREPARTICIPATION PHYSICAL EVALUATION HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep a copy of this form in the chart.) Date of Exam Name . Date of birth Sex _____ Age __ Grade ____ School _ Sport(s) Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking ☐ Yes ☐ No If yes, please identify specific allergy below. Do you have any allergies? ☐ Medicines ☐ Pollens ☐ Stinging Insects Explain "Yes" answers below. Circle questions you don't know the answers to. GENERAL QUESTIONS MEDICAL QUESTIONS Yes No. 26. Do you cough, wheeze, or have difficulty breathing during or 1. Has a doctor ever denied or restricted your participation in aports for after exercise? 2. Do you have any ongoing medical conditions? If so, please identify 27. Have you ever used an inhaler or taken asthma medicine? below: 🗆 Asthma 🗀 Anamia 🗀 Diabetes 🗀 infections 28. is there anyone in your family who has asthma? 29. Were you born without or are you missing a kidney, an eye, a testicle 3. Have you ever spent the night in the hospital? (males), your spleen, or any other organ? 4. Have you ever had surgery? 30. Do you have groin pain or a painful bulge or hemia in the groin area? HEART HEALTH QUESTIONS ABOUT YOU 31. Have you had infectious mononucleosis (mono) within the last month? 5. Have you ever passed out or nearly passed out DURING or 32. Do you have any rashes, pressure sores, or other sidn problems? 33. Have you had a herpee or MRSA skin infection? 6. Have you ever had discomfort, pain, lightness, or pressure in your 34. Have you ever had a head injury or concussion? chest during exercise? 35. Have you ever had a hit or blow to the head that caused confusion, 7. Does your heart ever race or skip beats (pregular beats) during exercise? prolonged headache, or memory problems? B. Has a doctor ever hild you that you have any heart problems? If so, 36. Do you have a history of seizure disorder? check all that apply: ☐ High blood pressure ☐ A heart murmur 37. Do you have headaches with exercise? 38. Have you over had numbness, tingling, or weakness in your arms or ☐ High cholesterol A heart Infection legs after being hit or falling? ☐ Kewasaki disease Other: 9. Has a doctor ever ordered a test for your heart? (For example, ECO/EKG, 39. Have you over been unable to move your erms or legs after being hit echocardiogram) 10. Do you get lightheaded or feel more short of breath than expected 40. Have you ever become ill while exercising in the heat? during exercise? 41. Do you get frequent muscle cramps when exercising? 11. Have you ever had an unexplained seizure? 42. Do you or someone in your family have sickle cell trait or disease? 12. Do you get more tired or short of breath more quickly than your friends 43. Have you had any problems with your eyes or vision? during exercise? 44. Have you had any eye injuries? HEART HEALTH QUESTIONS ABOUT YOUR FAMILY Yes No 45. Do you wear glasses or contact lenses? 13. Has any family member or relative died of heart problems or had an 46. Do you wear protective eyewear, such as goggles or a face shield? unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)? 47. Do you worry about your weight? 14. Does anyone in your family have hypertrophic cardiomycpathy, Martan 48. Are you trying to or has anyone recommended that you gain or syndrome, aritythmogonic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia? lase weight? 49. Are you on a special diet or do you avoid certain types of foods? 50. Have you ever had an eating disorder? Does anyone in your family have a heart problem, pecemaker, or implanted defibritiator? 51. Do you have any concerns that you would like to discuss with a doctor? FEMALES ONLY 16. Has anyone in your family had unexplained fainting, unexplained solzures, or near drowning? 52. Have you over had a menstrual period? BONE AND JOINT QUESTIONS Yes No 53. How old were you when you had your first menstrual period? 17. Have you ever had an injury to a bone, muscle, tigament, or tendon 54. How many periods have you had in the last 12 months? that caused you to miss a practice or a game? Explain "yes" answers here 18. Have you ever had any broken or fractured bones or dislocated joints? 19. Have you ever had an injury that required x-rays, MRI, CT scan, Injections, therapy, a brace, a cast, or crutches? 20. Have you ever had a stress tracture? 21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism) 22. Do you regularly use a brace, orthotics, or other assistive device? 23. Do you have a bone, muscle, or joint injury that bothers you? 24. Do any of your joints become painful, swollen, feel warm, or look rad? 25. Do you have any history of juvenile arthritis or connective tissue disease? I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. __ Signature of parent/guardian

■ PREPARTICIPATION PHYSICAL EVALUATION THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

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■ PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM

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■ PREPARTICIPATION PHYSICAL EVALUATION CLEARANCE FORM

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lame of physician, actv	sed practice nurse (APN), physician assistant (PA) Date
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