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 living in Alpha who plan on attending Phillipsburg High School are required to register with Alpha Public School to verify residency and to set up transportation. Please call us at (908) 454-5000. We will need **three** proofs of residency.

We require **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 Request Form from Alpha Public School.

In order for your child to be enrolled in the Phillipsburg High School you must complete their Registration Packet (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:



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	e Print & Complete "Each" Pagel)	DATE:	11
Full Legal Name: (Last, First, Middle	e)		
Address: (Number, Street, City, State	e, Zip)		
Home Telephone	Date of Birth (M/D/Y)	Place of Birth (City / State / Country)
Grade Level Year of H	HS Graduation Gender (M / F)	Send	ling District
Name of Previous School	Address	City	/ State / Zip
Has this student ever attended school	I in the Phillipsburg School District? If yes, when?	?	
Has this student ever attended school	l in New Jersey? ☐ Yes ☐ No		
RACE DATA: Please check the g	group(s) that best describes your child:		
☐ White ☐ Black/African Am	nerican 🔲 Asian 🔲 American Indian/A	Alaskan Native 🔲 N	lative Hawaiian/Other Pacific Islander
Please circle (Ethnicity: Hispa	nic – Yes / No) 3a) Language <u>first</u> ac	quired by Student:	
Student's <u>Primary</u> Language:	3c) Primary Language	Spoken at <u>Home</u> :	
If student was NOT born in the Uni	ted States, please indicate the date of US Ent	ry US Er	ntry to School
Parent/Guardian(s) With Whom Stude	ent Resides	Relati	onship to Student
All Other Members of Household	Relationship to Student	School Attending	Grade in School
		A.	
OFFICE USE ONLY: Dirth Cer	tificate □ Immunizations □ IEP □ C	Custody Tuition Let	iter School Records
Entry Date	School	ID Number	Grade
☐ Scanned ☐ Emailed	Registrar's	Initials	

Residency Status Confirmed Via Sending District Records.

PRIMARY PARENT/	GUARDIAN
Name:	
Relationship to Child:	□ Mother □ Father □ Other:
Mailing Address:	
	Provider:
Work Phone:	Email:
SPOUSE/SIGNIFICAL	NT OTHER
Relationship to Child:	□ Mother □ Father □ Other:
	Provider:
Work Phone:	Email:
Check appropriate boxes if may r Check appropriate boxes if studer	receive: Attendance Schedules Report Cards Discipline General Info nt may: See Go with Speak to Does not have contact with
SECONDARY PAREN	NT/GUARDIAN
Name:	
Relationship to Child:	□ Mother □ Father □ Other:
Mailing Address:	
Cell Phone:	Provider:
Work Phone:	Email:
	receive: Attendance Schedules Report Cards Discipline General Info nt may: See Go with Speak to Does not have contact with
THE CENTON CONTE	
EMERGENCY CONT	
Relationship:	Phone:

PL	EASE ANSWER THE FOLLOWI	NG. If you answer yes to any of these t	questions, piease complete the	# mitorination	<u>below</u> the question.
1.	Is there a custody/guardiansh	ip agreement? (Copy must be provided)	□Yes	□No
	Parent/Guardian of Record	All Market and the second seco	***************************************	······································	
2.	Is this student currently receiv	ving special education services? <u>Copy</u>	of IEP must be provided	□Yes	□No
	Date of Classification	Case Manager		7	Telephone
	If no, has student ever receive	d special education services?		□Yes	□No
3.	Has this student ever qualified	under Section 504 of the Rehabilitation	ı Act?	□Yes	□No
4.	is student in foster care or in a	a court placement?		□Yes	□No
	Name of Agency	Caseworker	Telephone	Date of Plac	ement
PA	Name of Agency RENT(S)/GUARDIAN: Please c		Telephone	Date of Plac	eement
			Telephone	Date of Plac	eement
Mil	RENT(S)/GUARDIAN: Please c	heck (√) appropriate box:	Telephone	Date of Plac	eement
Mil	RENT(S)/GUARDIAN: Please c itary Connected: Not Military Connected – Student	heck (√) appropriate box:	·		
Mil	RENT(S)/GUARDIAN: Please c itary Connected: Not Military Connected – Student Active Duty – dependent of a me	theck (√) appropriate box:	: Army, Navy, Air Force, Marine	Corps or Coa	
Mil	RENT(S)/GUARDIAN: Please c itary Connected: Not Military Connected – Student Active Duty – dependent of a me	t is not military connected The Active Duty Forces (Full Time	: Army, Navy, Air Force, Marine	Corps or Coa	
	RENT(S)/GUARDIAN: Please c itary Connected: Not Military Connected – Student Active Duty – dependent of a me National Guard or Reserve – Stu	t is not military connected The Active Duty Forces (Full Time	: Army, Navy, Air Force, Marine ational Guard or Reserve Forces	Corps or Coas	ist 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. Signed Relationship Date

PHILLIPSBURG SCHOOL DISTRICT

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 Engli 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 gua student use a language other than English more than half of the time. 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? VES or NO	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

	-			<u> </u>	
Student's Last Name:	and the second seco			**************************************	
Student's First Name:			······································		
School Attending (please circle):	PHS	PMS	PES	PPS	ECLC
Current Grade:					-
Name of Parent Requesting Access:					
(please circle):	Custodial P	arent	N	on-Custodial Pa	rent
Email address (required)*:_					
Language preferred in Parent Modu	ı <u>le</u> (please cir	·cle): En	nglish Sp	panish	
<u> Mobile Provider Used (pleas</u>				_	
Metro PCS / Nextel / Project	Fi / Sprint PC	CS / Straight T	alk / T-Mobile	/ Verizon / Virg	in Mobile
USA / Unknown / Other:					
*Confirmation of registration	on will be ser	nt to the <u>abov</u>	ve email addre	ss when activat	ed.
Are there any siblings in our school	district that	should he lin	ked to this ac		
Are there any sibilitys in our school	aistrict triat	SHOULD DE IIII	nea to tins act	ount:	
Student's Name:				School/Gr	ade:/
Student's Name:				School/Gre	ade:/
Student's Name:	***************************************	***************************************		School/Gr	ade:/
	i	Office Use Or	nly:		
Proof / Driver's License Submitted			-	JJ	Ву:



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 method the United States, in the past three year	ember performed any of the jobs listed belines?	ow temporarily or seasonally,in any part of
□ No		
Yes. Check all that apply and	ist the total number of months worked	d:
A Description of the Control of the		
	美人英英	
☐ Agriculture/Field Work (planting,	☐ Processing & Packaging (fruit,	
picking, sorting crops; soil preparation;	vegetables, chicken, eggs, pork, beef)	☐ Dairy/Cattle Raising
rrigation; fumigation)	vegetables, chicken, eggs, polk, beel)	(feeding, milking, rounding up)
Total Months Worked:	Total Months Worked:	Total Months Worked:
	《大教》	
	4	
		of section 1
Nursery/Greenhouse (planting,	□ Forestry (soil preparation, planting,	□ Commercial Fishing & Processing
otting, pruning, watering, harvesting)	cutting trees; landscaping not included)	(catching, sorting, packing, transporting)
otal Months Worked:	Total Months Worked:	Total Months Worked:
. In the past three years, has your	family moved to another state, city, sch	hool district, and/or county?
□ No □ Yes. How long have you reside e	d in your current address?	
Years	Months	Weeks
f you answered "Yes" to questions	1 and 2, please complete the informati	ion below.
Iome Street Address		Apt#
ity	State	Zip Code
elephone Number	Best Day of Week & Time o	of Day to Call
or School Use Only: Please send survey with t	wo YES responses to your district migrant liaison.	
udent State ID: En	rollment Date:	District ID:



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. <u>Elementary School</u> – Pre-school through 5 th 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) Must be filled out by parent/student and presented to physician	3 pages
at exam PHYSICAL EXAM (PART B NJDOE/AAPEF 10/07) Must be filled out by examining licensed provider at time of exam	3 pages
☐ Note to examining physician☐ Athletic Letter- School Sports Information (keep for reference)	1 page 1 page
Aution Long- Bondor Sports information (keep for reference)	I Dage

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



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.

- · · · · · · · · · · · · · · · · · · ·	at I understand that proof that a physical exam that st be returned to the school nurse within 30 days of ttend school without proof of his/her immunizations
Student Name:	Date of Birth:
Parent/Guardian Signature	Date



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	ormation is needed)
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	
Phillipsburg Middle School	200 Hillcrest Boulevard, Phillipsburg, NJ 08865
Phillipsburg High School	1 Stateliner Boulevard, Phillipsburg, NJ 08865



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 #
Mother Namework	#cell #
Emergency Contacts: must be able to reach school	ol in 30 minutes or less
1. Name	Relationship
Home #Work #	Cell #
2. Name	Relationship
Home #Work #	Cell #
Doctor Name	Phone #
Dentist Name	Phone #
Authorization for Emergency Treatment in In case of accident or serious illness when I cannot treatment and procedures as deemed necessary by the information with staff on a need to know basis. Hospital of Choice for Emergency Parent/Guardian Signature Procedures as deemed necessary by the information with staff on a need to know basis.	be contacted, I grant permission for emergency the physician AND sharing of any medical
Parent/Guardian SignaturePr	rinted NameDate
Does your child have Health Insurance? ☐ Yes, Name of insurance company	
No: NJ Family Care provides free or low cost le certain low income parents. For more information, www.njfamilycare.org to apply online. My name a Care Program to contact me about health insurance	please call 800-701-0710 or visit and address may be released to the NJ Family c.
Signature: Printe Written consent required pursuant to 20 U.S	ed Name: Date: S.C. 1232g (b)(1) and 34 C.F.R. 99.30 (b).



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	already on file with the school	l nurse.	
Allergies and Dietary Restrictions	Explain all "yes" answers h	elow	
Food		Yes	No
If yes, Must have yearly updated "Allergy Action	on Plan" filed with nurse		
Medication		Yes	No
Bee Sting	41.	Yes	No
Describe reaction (example: rash, difficulty be	eatning, anaphylaxis		
Medications Taken Regularly:	**************************************	Yes	– No
If medication is to be given in school,			
Must have yearly updated "In School Medicati List Medications and Reason for Use	on Authorization" filed with nurs	e	
General Medical Information Expl	ain all "ves" answers below		
Hospitalizations:	•	Yes	No
Operations:		Yes	No
Major Injuries, Broken/Fracture Bones:		Yes	No
Explain with date and age			
Serious Health Conditions Explain a	ll "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 behavi		Yes	No
Speech difficulty Slow learner	Bowel/bladder accidents		
Temper tantrums Overactive Ina			
	imals strangers darkness		_
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 member			
Please explain any family health history that yo	u would like to notify 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: 908-777-3980)

Policy Regarding Self-Administration of Medication

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.

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:				Vork Phone:		
MEDICATION	DOSAGE	/ ROUTE	FREQUENCY/ INDIC	CATION	SIDE EFFECTS	
<u> </u>	***					
Stude	ent may carry medication As ordered Omit		Student may self-administe		ES NO ust Schedule	
	Asthma A	ction Plan an	d Emergency Asthm	<u>ıa Policy</u>		
As	separate Asthma Ad	ction Plan should o	nly be submitted if the physi	cian does not	agree.	
 Students sl class. 	nowing marked imp	rovement after 10	breath, prescribed medication min. post-treatment observation after one dose of medication medication and the contract of the	tion will be per	rmitted to return to	
student and • Up to two (d seek physician ca	re. ents will be given a	at 20 minute intervals while a			
Physician's Signature		Physician Pho	one #	D	ate	
ndemnify and hold ha	an of this student, I re irmless the Phillipsbui inistration of the medi	rg School District, it's	allowed to receive the medications agents and employees from a	n prescribed ab ny and all liabilit	oove. I hereby agree to ty should any injury occur	
Parent / Guardian Sig	nature	Date	School Physician Signature		Date	

Revised 8/16

■ PREPARTICIPATION PHYSICAL EVALUATION HISTORY FORM

Varne			Date of birth		
Sex Age Grade Sci	nool _		Sport(s)		
Medicines and Avergies: Mease list all of the prescription and ove	r-the-co	ounter n	nedicines and supplements (herbal and nutritional) that you are current	y taking	;
Do you have any allergles? ☐ Yes ☐ No If yes, please ide ☐ Medicines ☐ Pollens	ntify sp	eclfic a	flergy below. Grood Stinging Insects		
xplain "Yes" answers below. Circle questions you don't know the an	SHOIS	ю.			***************************************
GENERAL QUESTIONS		No.	MEDICAL QUESTIONS	Yes	. No
1. Has a doctor ever denied or restricted your participation in aports for	-	135.57	26. Do you cough, wheeze, or have difficulty breathing during or	1	1
any reason?	<u> </u>	ļ	after exercise? 27. Have you ever used an inhalar or taken asthma medicine?	—	
2. Do you have any ongoing medical conditions? If so, please identify below: Asthma Anemia Diabetes hifections			28. Is there anyone in your family who has asthma?	-	-
Other:	<u> </u>		29. Were you bern without or are you missing a kidney, an eye, a testicle	╁──	+
3. Have you ever spent the night in the hospital?	 		(makes), your spicen, or any other organ?		
4. Have you ever had surgery? HEART HEALTH QUESTIONS ABOUT YOU	.¥es ;	%No ?	30. Do you have groin pain or a painful bulge or hemia in the groin area?	ـــــ	<u> </u>
5. Here you ever passed out or nearly passed out DURING or	3162	⊕ 180 .	31. Have you had infectious monoitudeosis (mone) within the last month? 32. Do you have any rashes, pressure soras, or other skin problems?	├	—
AFTER exercise?			33. Have you had a herpea or MRSA skin infection?	┼	┼─
 Have you ever had discomfort, pain, lightness, or pressure in your chest during exercise? 			34. Have you ever had a head injury or concussion?	 	†
Does your heart ever race or skip beats (tregular beats) during exercise?			35. Have you ever had a hit or blow to the head that caused confusion,		T
8. Has a doctor ever told you that you have any heart problems? If so,			prolonged headache, or memory problems? 36. Do you have a history of seizure disorder?	↓	╄
check all that apply: High blood pressure			37. Do you have headaches with exercise?	├	┼
☐ High cholesterol ☐ A heart Infection ☐ Kewasaki disease Other:			38. Have you ever had numbness, tingling, or weakness in your arms or legs after boing hit or falling?		<u> </u>
Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)			39. Have you ever been unable to move your arms or legs after being hit or falling?		
Do you get lightheaded or feel more short of breath than expected			40. Have you ever become III while exercising in the heat?		†
during exercise? 1. Have you ever had an unexplained seizure?			41. Do you get frequent muscle cramps when exercising?		
Do you get more thed or short of breath more quickly than your friends			42. Do you or someone in your family have sickle cell trait or disease?		
during exercise?			43. Have you had any problems with your eyes or vision? 44. Have you had any eye injuries?		╄
EART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	45. Do you wear glasses or contact lenses?	-	├──
Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (Including			46. Do you wear protective eyewoar, such as goggles or a face shield?	\vdash	
drawning, unexpiained car accident, or sudden infant death syndrome)?			47. Do you worry about your weight?		!
Does anyone in your family have hypotrophic certilomyopathy, Martan syndrome, unhythmogenic right ventricular cardiomyopathy, long OT			48. Are you trying to or has enjoye recommended that you gain or lose weight?		
syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?			49. Are you on a special diet or do you avoid certain types of toods?		
5. Does anyone in your family have a heart problem, pacemaker, or			50. Have you ever had an eating disorder?		
implanted defibritator?			51. Do you have any concerns that you would like to discuss with a doctor?		
Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?			FEMALES ONLY 52. Have you ever had a menstrual period?	4,4	
OHE AND JOINT QUESTIONS	Ves	No	53. How old were you when you had your first menstrual period?	ļl	L
7. Have you ever had an lojury to a bone, muscle, figament, 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	L	
8. Have you ever had any broken or fractured bones or dislocated joints? 9. Have you ever had an injury that required x-rays, MRI, CT scan,					
injections, therapy, a brace, a cast, or crutches?	1				
D. Have you ever had a stress tracture?					
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)			+		
Do you regularly use a brace, orthotics, or other assistive device?					
3. Do you have a bone, muscle, or joint injury that bothers you?					
4. Do any of your joints become painful, swotten, feet warm, or look rad?					
5. Do you have any history of juvenile arthritis or connective tissue disease? ereby state that, to the best of my knowledge, my answers to it					
	an ahai		diama ana annaninia and		

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

14. Have you ever been disgnosed with a heal-rained (hypothermia) lineas? 15. Do you have muscle spacicity? 16. Do you have muscle spacicity? 17. Do you have frequent seluces that cannot be controlled by medication? 18. Do you have frequent seluces that cannot be controlled by medication? 18. Do you have frequent seluces that cannot be controlled by medication? 18. Do you have frequent seluces that cannot be controlled by medication? 18. Do you have frequent seluces that cannot be controlled by medication? 18. Do you have frequent seluces that cannot be controlled by medication? 18. Do you have frequent seluces that cannot be controlled by medication? 18. Do you have frequent seluces that cannot be controlled by medication? 18. Do you have frequent seluces that cannot be controlled by medication? 18. Do you have frequent seluces that cannot be controlled by medication? 18. Do you have frequent seluces that cannot be controlled by medication? 18. Do you have frequent seluces that cannot be controlled by medication? 18. Do you have frequent seluces? 18. Do you have frequent seluces. 18. Do you have frequent seluces? 18. Do you have frequ	Name		Date of birth	
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ereby state that, to the best of my knowledge, my grawers to the above questions are complete and correct.	stantoadd Instability (-ray evaluation for allentoadd Instability bislocated joints (more than one) asy bleeding interged spleen lepabits isteopenia or osteoporosis bifficulty controlling bowel lifficulty controlling bladder lumbness or tingling in legs or feet leakness in arms or hands leakness in legs or feet ecent change in coordination ecent change in ability to walk pina bifida atex allergy plain "yas" answers here			
	ittentocodel Instability -ray evaluation for allentocodel Instability islocated joints (more than one) asy bleeding interged spleen lepatitis istificuity controlling bowel ifficuity controlling bladder umbness or tingling in legs or feet leakness in arms or hands leakness in legs or feet ecent change in coordination ecent change in ability to walk plaa bifida atex allergy plain "yas" answers here	ige, my snawers to the above questions are complete as		

■ PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM

Name			····				Date of birth
* Have you ever tale * Do you wear a sea 2. Consider reviewing o	questions en m od out or unde ad, hopeless, d t your home or d cigareties, ci daya, did you noi or use any u sn enabolic siz an any supplen t belt, use a ha uuestions on ca	r a lot of price to the control of t	eabure? or anxious? ? acco, anuff, o ag tobacco, s ?? ed any other ed condons! ar symptoms	nutf, or dip? performance supplement? r lose weight or improve your ? ! (questions 5-14).		Value of the second of the sec	
Height	omerable de de la se	Weight		D Male		A Million of the of	
BP /	(/)	Pulse	Vision	R 20/	L 20/	Corrected DY DN
MEDICAL		i grafika b	ija gir.		NORMAL	"表现的"。	ABNORMAL FINDINGS
Appearance Marfan stigmata (kypem span > height, in Eyes/eurs/nosa/throat Pupils equel Hearing	hoscoliosis, high yperlaxity, myon	h-arched pa lia, MVP, aor	late, pectus e tic insufficienc	xcavatum, arachnodactyly, cy)			
Lymph nodes							
Heart* • Murmurs (auscultation • Location of point of m			alva)				
Pulses Simultaneous femoral	như leiben ben	ne.					
Lungs	ariu taviai puis	-03				 	
Abdomen						 	
Genitourinary (males only	r ^a						
Skin HSV, lesions suggestin Neurologic*	e of MRSA, tine	a corporis					
MUSCULOSKELETAL.	19 12 to 180	1,125	1 2.73	ing rowner war j	MARKET TO LET	\$ 3.00.76	
Neck							
Back							
Shoulder/arm Elbow/lorearm						<u> </u>	
Wrist/hand/fingers			•	•		 	
l#p/thigh							
Knee							
Leg/ankle Foot/toes							
Functional						 	
 Duck-walk, single leg 	hop						
Consider ECA, echocardogram Consider GU exam H in private Consider cognitive evaluation of Cleared for all sports w Cleared for all sports w	eetting. Having th or baselina neurop ithout restriction	kd party presi sychiatric tes n	ent is recommen ling II a history o	ided.	at for		
☐ Not cleared							
	uriher evaluatio	n					
☐ For any s							
• • • • • • • • • • • • • • • • • • • •							
Reason							
Recommendations							
arlicipate in the sport(s) rise atter the athlete has o the athlete (and parent	as outlined at been cleared (s/guardians).	ove. A cop for particip	y of the phys ation, a physi	lcal exam is on record in my ician may rescind the clearan	oitice and can be mad se until the problem is	e available to the resolved and the	apparent clinical contraindleations to practice and a school at the request of the parents. If conditions a potential consequences are completely explained Date
ddress			7. E. Jaines	A - A Comment of the of			Phone
							TIME
2010 Amorican Acadamy	of Family Phys	iolana Amai	ican Acadams	of Decideries American Culture	of Cunde Madioine 4-	undana Madla-10-	and the Country Manufacture A. B. C. II.

■ PREPARTICIPATION PHYSICAL EVALUATION CLEARANCE FORM

MSHIRD	Sex D M D F Age	Date of birth
☐ Cleared fo	or all sports without restriction	
☐ Cleared fo	or all sports without restriction with recommendations for further evaluation or treatment for	
□ Not cleare	ad	
	□ Pending fwither evaluation	
	□ For any sports	
	For certain sports	
	Reason	
Recommendat	tions	

EMERGEN	CY INFORMATION	
Allergies		
·····		
Other Informati	ion	
dinical contr and can be m he physician	ined the above-named student and completed the preparticipation physical evaluation. The athle raindications to practice and participate in the sport(s) as outlined above. A copy of the physical nade available to the school at the request of the parents. If conditions arise after the athlete han may rescind the clearance until the problem is resolved and the potential consequences are colyguardians).	l exam is on record in my office
lame of physic	ician, advanced practice nurse (APN), physician assistant (PA)	Date
ddress		Phone
	ysiclan, APN, PA	
	rdiac Assesament Professional Development Module	
ate	Signature	
		6 :

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