Dear Parents and Guardians,

Please take a few minutes to review the attached forms. All are designed to provide the nurse at Indian Hill School with updated medical information about your child and ensure a smooth transition.

Parents and guardians of students entering Indian Hill School are required to provide the Health Office with an updated Health Appraisal Questionnaire.

I meet at the end of June with Ms. Wagner, the School Nurse at Indian Hill to briefly review the medical needs of the outgoing 3rd graders. Ms. Wagner periodically comes into her office and would be happy to speak to you in depth regarding your child. She may be contacted at the phone number listed below or by e mail (Bwagner@holmdelschools.org). We would also recommend that all renewals of Allergy Action Plans, Medication Authorization Forms, etc, be sent to her office prior to the beginning of school to facilitate a smooth transition.

Every child should receive an annual examination by his/her personal physician whenever possible as the health care provider can best guide and counsel parents in the important matters of proper growth and development, immunization deficits and other age related topics. Holmdel Township Board of Education requests that all students entering grades 4, 7 and 9 have an updated health examination.

I have also included a copy of the Medication Authorization Form. If your child currently has medication for his/her use at Village School and you wish to have it available at Indian Hill, complete this form. New forms must be completed every year. **Remember the nurse may not administer any medication, over the counter or prescription without this form signed by you and the doctor.**

You may send all completed forms to:

Barbara Wagner, RN
School Nurse (732) 946-1045
Indian Hill School
735 Holmdel Road
Holmdel, NJ 07733

Your attention to these matters will be greatly appreciated.

Sincerely,
Frances Flannelly, RN

# HOLMDEL TOWNSHIP PUBLIC SCHOOLS

Health Examination Form for New Students

Student's Name: _____

Address: _____

Date of Birth: _____ Age: _____

School: _____ Grade: _____

| | Date | Date | Date | Date | Date |
|---|---|---|---|---|---|
| DTAP | _____ | _____ | _____ | _____ | _____ |
| IPV/OPV | _____ | _____ | _____ | _____ | |
| Hepatitis A | _____ | _____ | _____ | | |
| Hepatitis B | _____ | _____ | _____ | | |
| Varivax | _____ | _____ | or disease date | _____ | _____ |
| MMR | _____ | _____ | | | |
| Measles | _____ | Mumps | _____ | Rubella | _____ |
| Mantoux Test | Date given:_____ | | Date read: _____ | | Result (MM)_____ |

| | Normal | Abnormal | Comments |
|---|---|---|---|
| Height _____ | ☐ | ☐ | _____ |
| Weight _____ | ☐ | ☐ | _____ |
| Eyes (i.e, Wears glasses?) | ☐ | ☐ | _____ |
| Ears | ☐ | ☐ | _____ |
| Respiratory | ☐ | ☐ | _____ |
| Cardiovascular | ☐ | ☐ | _____ |
| Blood Pressure _____ | ☐ | ☐ | _____ |
| Abdominal | ☐ | ☐ | _____ |
| Musculo-Skeletal | ☐ | ☐ | _____ |
| Skin | ☐ | ☐ | _____ |
| Neurological | ☐ | ☐ | _____ |
| Genitalia | ☐ | ☐ | _____ |

Other _____

_____

Presently taking medication? No ☐ Yes ☐

If yes, will this be taken during school? No ☐ Yes ☐

If yes, please provide a doctor's prescription/order to the school nurse as per attached form.

Restrict in Physical Education? No ☐ Yes ☐

Please explain _____

Examining Physician (type or print) _____

Physician's Signature _____ Date _____

Physician's Address _____ Telephone No. _____

# HOLMDEL TOWNSHIP PUBLIC SCHOOLS
# SCHOOL HEALTH SERVICES PROGRAM

## AUTHORIZATION FOR MEDICATION TO BE TAKEN DURING SCHOOL HOURS OR SCHOOL SPONSORED ACTIVITIES

A. **This section is to be completed by the parent or guardian**

Child's Name: _____
Last First

Date of Birth: _____ Gender: _____

Physician's Name: _____

Physician's Telephone Number: _____

_____ I request that my child be assisted in taking the medicine(s) described below at school, by legally authorized persons.

_____ I request that my child be permitted to self-administer the medicine(s), **for a *life-threatening illness,** which are described below.

**Life-threatening illness means an illness or condition that requires an immediate response to specific symptoms or sequelae that if left untreated may lead to potential loss of life such as, but not limited to, the use of an inhaler to treat an asthma attack or the use of an adrenalin injection to treat a potential anaphylactic reaction.*

Parent's/Guardian's Name: _____
(Please print)

Parent's/Guardian's Signature: _____

Home Telephone Number: _____ Emergency Telephone Number: _____

B. **This section is to be completed by the physician:**

| | |
|---|---|
| Name of Medicine | |
| Form | |
| Dose | |
| If prescribed daily, what time? | |
| If prescribed "when needed," describe indications | |
| How soon can the medication dose be repeated? | |
| List significant side effects | |
| Is this medication for a life-threatening illness? | |
| Is the child authorized to self-administer the medication? | |
| Has the child been trained by the physician? | |
| Length of time this treatment is recommended? | |
| Other information or concerns | |

_____ Date: _____
(Physician's signature)

(Form Created September 2008)

# HOLMDEL TOWNSHIP PUBLIC SCHOOLS
## CONFIDENTIAL HEALTH APPRAISAL QUESTIONNAIRE

Name: _____ Date of Birth: _____

Home Address: _____

_____

School: _____ Grade: _____

Pediatrician: _____

Pediatrician's Telephone Number: _____

Date of Last Examination by Pediatrician: _____

**Birth History:**

1) What was your child's birth weight? _____
2) When did the baby leave the nursery? _____ days of age
3) Was he/she born with any birth defects? NO _____ YES _____

**Past history:**

Has your child had:

| | Date/Year | Complications |
|---|---|---|
| Measles | | |
| Mumps | | |
| Chicken Pox | | |
| Rubella (German Measles) | | |
| Scarlet Fever | | |
| Meningitis | | |
| Encephalitis | | |
| Prolonged or unexplained high fever | | |
| Concussion | | |

- MORE -

Has your child had any of the following:

| | Age | Diagnosis |
|---|---|---|
| Serious Accident | | |
| Broken Bones | | |
| Surgery | | |
| Hospitalizations | | |
| Other Illnesses | | |

Has your child ever had a convulsion (seizure)? NO _____ YES _____
Has your child ever had trouble with hearing? NO _____ YES _____
Has your child ever had trouble with vision? NO _____ YES _____
Does your child wear glasses or contact lenses? NO _____ YES _____
Is your child allergic? NO _____ YES _____

If YES, to what? _____
Eczema or hives _____
Asthma _____
Medications _____

Is your child presently receiving allergy shots? _____
Is your child taking any medicine now? _____
When did your child last see a dentist? _____

**Family History:**

Have any of the child's parents, grandparents, aunts, uncles, brothers, or sisters had:

_____ Seizures
_____ Diabetes
_____ Cancer
_____ Tuberculosis
_____ Asthma
_____ Hay Fever
_____ Heart Disease
_____ Anemia or bleeding problems
_____ Rheumatic fever

**IMMUNIZATIONS RECORDS MUST BE ATTACHED.**

Students will not be admitted to school unless immunizations meet state requirements

Signature of Parent or Guardian _____

Date: _____