Audubon Public Schools
350 Edgewood Avenue, Audubon, New Jersey 08106-1545
Phone (856) 547-7695 • Fax (856) 546-8550
www.audubonschools.org

HEALTH HISTORY

Student Name _____ **Grade** _____

Date of Birth _____ **Age**_____ **Sex:** **Male** ☐ **Female** ☐

Does your child have any of the following:

	No	Yes	
Allergy: • Bee Sting • Food • Medication **Epinephrine Ordered by Doctor**	☐	☐	bee sting reaction: _____ food & reaction: _____ medication & reaction:_____ Click here for HEALTHCARE PROVIDER'S ORDERS FOR ALLERGY EMERGENCY TREATMENT PACKET
Allergies: Hayfever/Seasonal	☐	☐	season & symptoms:
ADD/ADHD	☐	☐	
Anemia	☐	☐	
Asthma	☐	☐	mild☐ severe☐ Click here for the ASTHMA TREATMENT PLAN – required by N.J. Law
Behavioral Issues	☐	☐	
Broken Bone History	☐	☐	
Chronic Constipation	☐	☐	
Developmental Delay	☐	☐	
Dental Problems	☐	☐	
Diabetes	☐	☐	
Eczema	☐	☐	
Fainting Spells	☐	☐	
Frequent Ear Infections • Earaches • Hearing Loss • Tubes in Ears	☐	☐	
Headaches	☐	☐	
Muscle Problems	☐	☐	
Nosebleeds	☐	☐	
Physical Handicap	☐	☐	
Premature or Low Birth Weight	☐	☐	
Seizures/Epilepsy/Tics	☐	☐	
Speech Difficulty or Delay	☐	☐	
Stomachaches	☐	☐	
Vision problem • Color Deficiency • Corrective Lenses • Patch	☐	☐	type of corrective lens?_____ right☐ left☐

Has your child had any of the following:

Illness	No	Yes	Date(s) of Illness
Chickenpox	☐	☐	
Measles	☐	☐	
Mumps	☐	☐	
German Measles	☐	☐	
Lyme Disease	☐	☐	
Strep. Infection	☐	☐	
Scarlet Fever	☐	☐	
Rheumatic Fever	☐	☐	
Pneumonia	☐	☐	
Hepatitis (type)	☐	☐	
Mononucleosis	☐	☐	

Student Name _____ Date of Birth_____

Is your child currently receiving daily medication? **NO**___ **YES**___

- If YES, please give name of medication, amount and reason: _____
- Will your child require the medication during school hours? **NO**___ **YES**___

Click here for the MEDICATION CONSENT FORM, which must be completed by parent and doctor for any medication, including over the counter medication, which needs to be given during school hours.

Was a health problem and/or handicap present at birth? **NO**___ **YES**___

- At what age was diagnosis made? _____
  Diagnosis:_____

List any operations, injuries or hospitalizations and dates:

Operations/Injuries/Hospitalizations	***Date***
_____	_____
_____	_____
_____	_____

- Do any of the conditions still affect your child? **NO**___ **YES**___
- If YES, please list_____
- Physical Ed Activity: Does condition restrict his/her activities? **NO**___ **YES**___

Do you have any concerns about your child's health? If so, please describe_____

I give permission for health concerns to be shared with appropriate staff having contact with my child
YES___ **NO**___

Routine screenings are performed, in the Audubon Public schools, by certified school nurses as part of a comprehensive health program required by New Jersey law. Pupils can be exempted from screenings with a written request from the parent/guardian.

Authorization for Medical Treatment

*I/We, the undersigned, do hereby authorize officials of the Audubon School District to contact directly the persons named on the "**EMERGENCY CONTACT INFORMATION**" and do authorize the appropriate school personnel to render first aid as may be deemed necessary in an emergency, for the health of the said child. Pertinent medical information may be shared with school personnel as needed.*

*In the event that parents or other persons named on the "**EMERGENCY CONTACT INFORMATION**" cannot be contacted, the school officials are hereby authorized to take whatever action necessary in their judgment, for the health of aforesaid child, including transportation to the nearest medical emergency facility.*

I will not hold the Audubon School District financially responsible for the emergency care and/or transportation for said child.

Name of Child's Doctor:_____**Telephone #**_____
Date of Last Medical Exam: _____

Name of Child's Dentist:_____**Telephone #**_____
Date of Last Dental Exam: _____

Health Insurance Information: Does child have health insurance?

YES___ Name of Insurance:_____
Name of Subscriber: _____
I.D. Number:_____
Group Number:_____

NO___ Do you want Medicaid/NJ Family Care to contact you about free or low-cost health insurance? No___Yes___

Parent/Guardian Printed Name_____**Signature** _____Date_____

Parent/Guardian Printed Name_____**Signature** _____Date_____

Audubon Public Schools Physical Exam and Immunization Record for Students in Pre-K through Grade 5

Name _____Grade _____ Birthdate _____

Physical Exam

Ears_____Hearing_____
Eyes_____Vision_____
Lymph Glands _____
Thyroid_____
Nose_____
Throat_____
Teeth-Mouth _____
Heart_____
Lungs_____
Abdomen _____
Hernia_____
Genito-urinary _____

Orthopedic
Structural _____
Posture_____
Feet _____

Skin _____
Nutrition_____
Nervous System_____
Speech _____
Other _____
General Appearance_____

Medical Illnesses_____
Medications_____

Allergies_____
Reaction_____

Height_____Weight_____
Blood Pressure_____

Recommendations_____

State what, if any, modifications are required for student's full participation in school program_____
_____

Date of physical exam:_____
Dr.'s Name (printed or stamped)

Immunizations

complete **or** attach immunization record

DTP_____
_____
_____
_____
_____
Tdap _____ (grade 6)

Polio_____
_____
_____
_____
_____

MMR_____
MMR Booster_____

Hib_____
_____
_____
_____

Hepatitis B_____
_____
_____

Varicella Vaccine_____ _____
History or Lab Evidence of Varicella_____

Hepatitis A Vaccine_____ _____

Pneumococcal conjugate series
#1_____ #2_____ #3_____#4_____(13)_____

Meningococcal vaccine _____(grade 6)
Menactra_____or Metamune_____

Hepatitis A_____

Influenza Vaccine_____
(required annually until age 5)

TB Screening Tested _____
Read _____
Result _____

Dr.'s Signature:_____

Audubon Public Schools

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RELEASE FOR STUDENT RECORDS/VERBAL INFORMATION

_____ _____ _____ _____
Student's Last Name **First Name** **Middle Name** **Suffix**

D.O.B.: _____

School Last Attended: _____**Grade Last Attended**_____

Address _____
Bldg.# *Street* *City* *State* *Zip Code*

Tel. No. ( ) _____ **Fax No.** ( ) _____

This child has registered in our school for the current year. Please forward the following information:

- ☐ Official Transcript
- ☐ Standardized Test Records
- ☐ Health Records
- ☐ Others_____
- ☐ State Issued ID (**SID #**)
- ☐ Disciplinary Records
- ☐ **Special Education & Related Services Records**

To the school / office checked below:

☐ **HAVILAND AVENUE ELEM. SCHOOL**
240 South Haviland Avenue
Audubon, NJ 08106
Phone: 856-546-4922
Fax: 856-547-1248

☐ **MANSION AVENUE ELEM. SCHOOL**
300 Mansion Avenue
Audubon, NJ 08106
Phone: 856-546-4926
Fax: 856-547-1483

☐ **JR/SR HIGH SCHOOL**
350 Edgewood Ave.
Audubon, NJ 08106
Phone: 856-547-7695
Fax: 856-547-1901

To Whom It May Concern:

This will serve as authorization to send the records requested above to the Audubon Public Schools.

_____ _____
Parent / Guardian Printed Name **Parent / Guardian Printed Name**

_____ _____
Parent / Guardian Signature **Parent / Guardian Signature**

_____ _____
Date **Date**

Information Regarding
SEMI Parental Consent

Background: The State of New Jersey has participated in a Federal program, Special Education Medicaid Initiative (SEMI), since 1994. The program assists school districts by providing partial reimbursement for medically-related services listed on a student's Individualized Educational Program (IEP).

The SEMI program is under the auspices of the New Jersey Department of the Treasury through its collaboration with the New Jersey Department of Education and New Jersey Division of Medicaid Assistance and Health Services.

In 2013, the regulations regarding Medicaid parental consent for school-based services changed. Now the regulations require that, prior to accessing a child's public benefits or insurance for the first time, and annually thereafter, school districts must provide parents/guardians written notification and obtain a one-time parental consent.

Is there a cost to you?
No. IEP services are provided to students while at school at **no** cost to the parent/guardian.

Will SEMI claiming impact your family's Medicaid benefits?
The SEMI program **does not** impact a family's Medicaid services, funds, or coverage limits. New Jersey operates the school-based services program differently than the family's Medicaid program. The SEMI program **does not** affect your family's Medicaid benefits in any way.

What type of services does the School-Based Services program cover?

- Evaluations
- Speech Therapy
- Occupational Therapy
- Physical Therapy
- Psychological Counseling
- Audiology
- Nursing
- Specialized Transportation

What type of information about your child will be shared?
In order to submit claims for SEMI reimbursement, the following types of records may be required: first name, last name, middle name, address, date of birth, student ID, Medicaid ID, disability, service dates and the type of services delivered.

Who will see this information?
Information about your child's special education program may be shared with the New Jersey Division of Medicaid Assistance and Health Services and its affiliates, including the Department of the Treasury and the Department of Education for the purpose of verifying Medicaid eligibility and submitting claims.

What if you change your mind?
You have the right to withdraw consent to allow for Medicaid billing at any time. If you would like to revoke consent, please contact the school in which your child is enrolled in writing.

Will your consent or refusal to consent affect your child's services?
No. Your school district is still required to provide services to your child pursuant to his or her IEP, regardless of your Medicaid eligibility status or your willingness to consent for SEMI billing,

What if you have questions?
Please call your school district's Special Education department with questions or concerns, or to obtain a copy of the parental consent form.

AUDUBON PUBLIC SCHOOLS
CHILD STUDY TEAM
350 Edgewood Avenue, Audubon, New Jersey 08106
Phone: (856) 547-7695, ext. 4152 Fax: (856) 547-2303

Special Education Medicaid Initiative (SEMI) Parental Consent Form

Audubon School District

Our school district is participating in the Special Education Medicaid Initiative (SEMI) program that allows school districts to bill Medicaid for services that are provided to students.

In accordance with the Family Educational Rights and Privacy Act, 34 CFR §99.30 and Section 617 of the IDEA Part B, consent requirements in 34 CFR §300.622 require a one-time consent before accessing public benefits.

This consent establishes that your child's personally identifiable information, such as student records or information about services provided to your child including evaluations, and services as specified in your child's Individualized Education Program (IEP) (occupational therapy, physical therapy, speech/language therapy, psychological counseling, audiology, nursing and specialized transportation) may be disclosed to Medicaid and the Department of the Treasury for the purpose of receiving Medicaid reimbursement at the school district.

Please complete the information on the form, sign and return it at your earliest convenience to the address above. Elementary students may return the form in a sealed envelope labeled CST to their teacher who will forward it to the Child Study Team office. High school students may return the form in a sealed envelope to the Child Study Team office. Thank you.

As parent/guardian of the child named below, I give permission to disclose information as described above and I understand and agree that Medicaid may access my child's or my public benefits or insurance to pay for special education or related services under Part 300 (services under the IDEA). I understand that the school district is still required to provide services to my child pursuant to his or her IEP, regardless of my Medicaid eligibility status or willingness to consent for SEMI billing.

I understand that billing for these services by the district *does not* impact my ability to access these services for my child outside of the school setting, nor will any cost be incurred by my family including co-pays, deductibles, loss of eligibility or impact on lifetime benefits.

Child's Name: _____

Child's Date of Birth: _____

Parent/Guardian Signature: _____ Date: _____

I give consent to bill for SEMI: Yes ☐ No ☐

This consent can be revoked at any time by contacting the administrator at your child's school, in writing.

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STUDENT RESIDENCY VERIFICATION

STUDENT NAME_____ **GRADE**_____

School:

☐ Haviland Avenue Elementary School ☐ Mansion Avenue Elementary School ☐ Jr/Sr High School

In accordance with New Jersey state law (NJSA 18A:38-1 and 18A-7B-12), it is necessary to determine the residency of students entering the school district.

Please indicate the applicable student resident facility:

1 . ☐ Own my own residence within Audubon Borough

2 . ☐ Rent my residence within Audubon Borough

3 . ☐ Share housing and expenses in Audubon Borough with family member / friend by choice

4 . ☐ Reside with family member / friend in Audubon Borough due to economic hardship

5 . ☐ Reside in domestic violence shelter / runaway youth shelter / other shelter, or any other transitional living program

6 . ☐ Reside in motel, hotel, park, or campground due to lack of adequate housing

7 . ☐ Reside in car or RV or in a public place (such as a bus station)

8 . ☐ Reside in sub-standard housing, such as an abandoned building

9 . ☐ Student(s) awaiting foster care placement

10. ☐ Parents are migrant workers

11. ☐ Reside in home for adolescent school-age mothers

12. ☐ Other: Please explain - _____

☐ **NONE OF THE ABOVE SITUATIONS APPLY**

_____	_____	_____
Parent / Guardian Printed Name	**Parent / Guardian Printed Name**	**Date**
_____	_____	_____
Parent / Guardian Signature	**Parent / Guardian Signature**	**Date**

-OR-

_____	_____	_____
Unaccompanied Youth – Print Name	**Unaccompanied Youth-Signature**	**Date**