



## **BRIGHT BEGINNINGS LEARNING CENTER**

<https://www.escnj.us>

EDUCATIONAL SERVICES COMMISSION OF NEW JERSEY

1660 Stelton Road, Piscataway, New Jersey 08854 (732) 339-9331 Fax (732) 339-9441

**Kate Johnson**  
Principal

**Jenn Nesi**  
Vice Principal

School Year: **2024-2025**

Dear Parent/Guardian:

The Bright Beginnings Learning Center Health Packet is enclosed for completion.

School laws require that your child be given a physical examination for the protection of health. The examination should be scheduled for new entrants into the school system, as well as subsequent examinations of students at least one time during each developmental stage, that is; early childhood (preschool through grade three), preadolescence (grades four through six) and adolescence (grade seven through twelve).

The primary responsibility for the total health needs for the school child rests with the family and the student's own physician. A physical examination by a private physician allows a more thorough examination and a more individual approach to each pupil and his problems. It will also provide an opportunity to receive additional immunization if needed.

Please have the enclosed examination form completed by your physician and return it to the school health office. Also, please read and fill out the additional forms enclosed.

If there is any need for additional information, please do not hesitate to contact us at  
**(732) 339-9331 extension 3470 or 3480.**

Please be advised that this information is essential, and must be kept on file at Bright Beginnings Learning Center.

Your cooperation in this matter will be greatly appreciated.

Yours truly,

*Dahlia Burrell-Thompson*  
Dahlia Burrell-Thompson, RN BSN CSN  
School Nurse

*Joy Figueroa*  
Rowena Joy Figueroa, RN BSN CSN  
School Nurse

**APPENDIX H**

**UNIVERSAL  
CHILD HEALTH RECORD**

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

<b>SECTION I - TO BE COMPLETED BY PARENT(S)</b>					
Child's Name (Last)		(First)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /
Does Child Have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Name of Child's Health Insurance Carrier			
Parent/Guardian Name		Home Telephone Number ( ) -		Work Telephone/Cell Phone Number ( ) -	
Parent/Guardian Name		Home Telephone Number ( ) -		Work Telephone/Cell Phone Number ( ) -	
<b>I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.</b>					
Signature/Date				This form may be released to WIC. <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER</b>					
Date of Physical Examination:			Results of physical examination normal? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Abnormalities Noted:			Weight (must be taken within 30 days for WIC)		
			Height (must be taken within 30 days for WIC)		
			Head Circumference (if <2 Years)		
			Blood Pressure (if ≥3 Years)		
<b>IMMUNIZATIONS</b>			<input type="checkbox"/> Immunization Record Attached <input type="checkbox"/> Date Next Immunization Due: _____		
<b>MEDICAL CONDITIONS</b>					
Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Medications/Treatments • List medications/treatments:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Limitations to Physical Activity • List limitations/special considerations:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Special Equipment Needs • List items necessary for daily activities		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Allergies/Sensitivities • List allergies:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
<b>PREVENTIVE HEALTH SCREENINGS</b>					
Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: <input type="checkbox"/> Capillary <input type="checkbox"/> Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		
<input type="checkbox"/> I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.					
Name of Health Care Provider (Print)			Health Care Provider Stamp:		
Signature/Date					



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**HEALTH SCREENING**

Dear Parent/Guardian:

In accordance with New Jersey Law, N.J.A.C.6A:16-2.2, each district Board of Education will ensure health screenings for students. Health screenings may include height, weight, hearing, blood pressure, vision and scoliosis. Screenings may be conducted by a school physician, school nurse, or other school personnel properly trained.

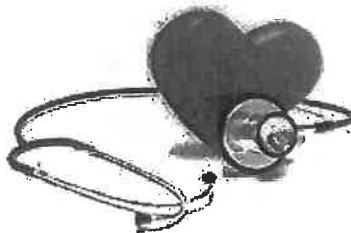
Please complete the health screening permission form below and return to the Bright Beginnings Learning Center Health Office.

**STUDENT'S NAME:** \_\_\_\_\_

\_\_\_\_\_ I give permission for my child to participate in health screenings at school.

\_\_\_\_\_ I do not give permission for my child to participate in health screenings at school.

**Signature of Parent or Guardian** \_\_\_\_\_ **Date:** \_\_\_\_\_





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## AUTHORIZATION FOR NON-PRESCRIPTION MEDICATION

Dear Parent/Guardian:

Sometimes children develop fever, headaches, or pain due to illness or from a simple injury while they are at school. The school nurse would like your permission to administer over-the-counter medication to your child when it happens. We will usually use acetaminophen (sold as Tylenol). The dose will be according to the child's weight and will be set by our school physician. You may prefer another medication such as ibuprofen, (sold as Advil and Motrin). Ibuprofen is also preferred for menstrual cramps. The school will supply Tylenol and Motrin. If you wish to give the nurse permission to use one of these medications for fever, pain or menstrual cramps, please sign the appropriate line or lines below.

(Name of Child):

\_\_\_\_\_

I give permission for the school nurse,

\_\_\_\_\_ To administer acetaminophen (ex. Tylenol)

\_\_\_\_\_ To administer ibuprofen (ex. Advil/Motrin)

Also, sometimes children develop allergic reactions (itching, swelling, or rash) while they are in school. The school nurse would like your permission to administer over-the-counter medication to your child when it happens. We will usually use diphenhydramine (sold as Benadryl). If you wish to give the nurse permission to use one of these medications for allergic reaction, please select and sign the line below.

\_\_\_\_\_ Para administrar difenhidramina (Benadryl)

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_



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Our school's health office recommends an annual dental examination by your family dentist for your child.

Please return this form to the school nurse as soon as possible following your child's dental examination.

If there is any reason why you cannot have a dental examination done, please call 732-339-9331 ext. 3470/3480.

School Nurse

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**DENTAL EXAMINATION REPORT**

I have examined \_\_\_\_\_ on \_\_\_\_\_  
(Name of student) (Date)

- 1. There is no need for corrective work at this time.
- 2. Treatment has been completed.
- 3. There is a need for dental care at this time.

An appointment has been scheduled: YES \_\_\_\_\_ NO \_\_\_\_\_  
(Date of next Appointment)

Medical Provider Signature: \_\_\_\_\_

Medical Provider Print Name: \_\_\_\_\_

