

## **Mandatory Medical Information and Documents for New Students**

Welcome to Collier School,

To ensure the health and safety of your child please return the following 3 documents as soon as possible directly to the school nurse:

Theresa Alves RN-High School, [talves@collieryouthservices.org](mailto:talves@collieryouthservices.org) (732) 946-4771 ext. 312

Lisa Kaplan RN-Middle School, [lkaplan@collieryouthservices.org](mailto:lkaplan@collieryouthservices.org) (732) 946-4771 ext. 255

- **Universal Child Health Record/Physical Examination Form: This is to be completed by your child's primary care provider (Pediatrician).** All students must provide proof of a Physical Examination within their first 30 days at Collier. A copy of a Physical Exam done within the past 365 days is acceptable. Forms to provide to healthcare providers can be found at:  
<https://www.nj.gov/health/forms/ch-14.pdf>
- **Student Health History Form:** the nurses need to have current health information for your child. This form must be completed annually and is found on the Collier School Website under Documents and Forms.
- **OTC (Over The Counter) Medication Form:** if you want your child to receive Tylenol, Advil, Tums, or Benadryl at school. This form must be completed annually and is found on the Collier School Website under Documents and Forms.

**ONLY IF** your child requires any of the following at school, should these form(s) be completed and returned. All forms are also on the Collier HS or MS website:

- Medication Administration Form - should your child require prescription medication to be administered at school
- Asthma Treatment Plan - if your child has asthma and requires medication in school.
- Food Allergy Action Plan - should your child be prescribed Epinephrine for anaphylaxis
- Seizure Action Plan - should your child require medical assistance during a seizure.

If your child wants to play sports at Collier School please print out the Sports Physical Packet on the CHS website under the "Documents & Forms-Nurse Forms" tab, you will find documents related to Sports Physicals.

- All forms are on the Collier HS and MS websites under the tab "Documents & Forms-Nurse Forms" (link: <https://www.collierhighschool.com/parents-students/documents-and-forms>)

# UNIVERSAL CHILD HEALTH RECORD

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

SECTION I - TO BE COMPLETED BY PARENT(S)			
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	

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER			
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: _____
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MEDICAL CONDITIONS		
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

PREVENTIVE HEALTH SCREENINGS					
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"/> <b>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.</b>	
Name of Health Care Provider (Print)	Health Care Provider Stamp:
Signature/Date	

# Instructions for Completing the Universal Child Health Record (CH-14)

## Section 1 - Parent

Please have the parent/guardian complete the top section and sign the consent for the child care provider/school nurse to discuss any information on this form with the health care provider.

The WIC box needs to be checked only if this form is being sent to the WIC office. WIC is a supplemental nutrition program for Women, Infants and Children that provides nutritious foods, nutrition counseling, health care referrals and breast feeding support to income eligible families. For more information about WIC in your area call 1-800-328-3838.

## Section 2 - Health Care Provider

1. Please enter the date of the physical exam that is being used to complete the form. Note significant abnormalities especially if the child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing etc.)

- **Weight** - Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within the last 30 days.
- **Height** - Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within the last 30 days.
- **Head Circumference** - Only enter if the child is less than 2 years.
- **Blood Pressure** - Only enter if the child is 3 years or older.

2. **Immunization** - A copy of an immunization record may be copied and attached. If you need a blank form on which to enter the immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Department of Health, Vaccine Preventable Diseases Program at 609-826-4860. The Immunization record must be attached for the form to be valid.

- "Date next immunization is due" is optional but helps child care providers to assure that children in their care are up-to-date with immunizations.

3. **Medical Conditions** - Please list any ongoing medical conditions that might impact the child's health and well being in the child care or school setting.

- a. Note any significant medical conditions or major surgical history. **If the child has a complex medical condition, a special care plan should be completed and attached for any of the medical issue blocks that follow.** A generic care plan (CH-15) can be downloaded at [www.nj.gov/health/forms/ch-15.dot](http://www.nj.gov/health/forms/ch-15.dot) or pdf. Hard copies of the CH-15 can be requested from the Division of Family Health Services at 609-292-5666.

- b. **Medications** - List any ongoing medications. Include any medications given at home if they might impact the child's health while in child care (seizure, cardiac or asthma medications, etc.). Short-term medications such as antibiotics do not need to be listed on this form. Long-term antibiotics such as antibiotics for urinary tract infections or sickle cell prophylaxis should be included.

PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigger medication administration.

*Please be specific about what over-the-counter (OTC) medications you recommend, and include information for the parent and child care provider as to dosage, route, frequency, and possible side effects. Many child care providers may require separate permissions slips for prescription and OTC medications.*

c. **Limitations to physical activity** - Please be as specific as possible and include dates of limitation as appropriate. Any limitation to field trips should be noted. Note any special considerations such as avoiding sun exposure or exposure to allergens. Potential severe reaction to insect stings should be noted. Special considerations such as back-only sleeping for infants should be noted.

d. **Special Equipment** - Enter if the child wears glasses, orthodontic devices, orthotics, or other special equipment. Children with complex equipment needs should have a care plan.

e. **Allergies/Sensitivities** - Children with life-threatening allergies should have a special care plan. Severe allergic reactions to animals or foods (wheezing etc.) should be noted. Pediatric asthma action plans can be obtained from The Pediatric Asthma Coalition of New Jersey at [www.pacnj.org](http://www.pacnj.org) or by phone at 908-687-9340.

f. **Special Diets** - Any special diet and/or supplements that are medically indicated should be included. Exclusive breastfeeding should be noted.

g. **Behavioral/Mental Health issues** - Please note any significant behavioral problems or mental health diagnoses such as autism, breath holding, or ADHD.

h. **Emergency Plans** - May require a special care plan if interventions are complex. Be specific about signs and symptoms to watch for. Use simple language and avoid the use of complex medical terms.

4. **Screening** - This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public health personnel to track children's health. Please enter the date that the test was performed. Note if the test was abnormal or place an "N" if it was normal.

- For lead screening state if the blood sample was capillary or venous and the value of the test performed.
- For PPD enter millimeters of induration, and the date listed should be the date read. If a chest x-ray was done, record results.
- Scoliosis screenings are done biennially in the public schools beginning at age 10.

This form may be used for clearance for sports or physical education. As such, please check the box above the signature line and make any appropriate notations in the Limitation to Physical Activities block.

5. Please sign and date the form with the date the form was completed (note the date of the exam, if different)

- Print the health care provider's name.
- Stamp with health care site's name, address and phone number.

# COLLIER SCHOOL

## Student Health History

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: \_\_\_\_\_

Dear Parent/Guardian,

Please complete the following Health Questionnaire for your child and notify your child's school nurse should any health or medication changes occur during the school year.

- Allergies to (Please check all that apply): Food (type) \_\_\_\_\_  
Insect sting \_\_\_\_\_ Latex \_\_\_\_\_ Seasonal \_\_\_\_\_ Other/Unknown \_\_\_\_\_  
Type of Reaction: Mild \_\_\_\_\_ Moderate \_\_\_\_\_ Anaphylactic \_\_\_\_\_  
Please provide a completed **Emergency Allergy Form** for Epinephrine if needed.
- Asthma \_\_\_\_\_ If an inhaler/Nebulizer is needed in school please provide a completed **Asthma Treatment Plan**.
- Seizures/Epilepsy \_\_\_\_\_ If yes, please provide a copy of the **Seizure Action Plan**.
- Diabetes Type 1 \_\_\_\_\_ If yes, Please provide the **Diabetes Medical Management Plan**  
Diabetes Type 2 \_\_\_\_\_
- Celiac Disease, IBS or Other Gastrointestinal Issues (please specify) \_\_\_\_\_
- Incontinence issues/bladder/kidney condition type \_\_\_\_\_
- Muscle/Bone Disorder & Type \_\_\_\_\_ Arthritis \_\_\_\_\_
- Cardiac/Heart Disease & Type \_\_\_\_\_
- Excessive Headaches and/or Migraines \_\_\_\_\_
- Vision problems (Please specify) \_\_\_\_\_ Glasses \_\_ yes no \_\_
- Hearing issues (please specify) \_\_\_\_\_
- Excessive nosebleeds or other bleeding issues \_\_\_\_\_
- Scoliosis \_\_\_\_\_ Sickle Cell Anemia \_\_\_\_\_
- Eating Disorder/Feeding Issues \_\_\_\_\_
- Other Health conditions not listed \_\_\_\_\_

Does your child take medication daily? If so please list medication name, dosage and time:

\_\_\_\_\_

Has your child had surgery within the past year? If so please list type of surgery below:

\_\_\_\_\_

Is there anything more the nurse should know concerning your child's health? Please list:

\_\_\_\_\_

I/We give permission for the nurse to disclose this health information with school staff on a Need to know basis. Please be assured that any health information will be treated with confidentiality.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**COLLIER SCHOOLS**

**160 Conover Rd.**

**Wickatunk, NJ 08859**

Student Name: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medical Conditions: \_\_\_\_\_

Daily Medications: \_\_\_\_\_

\*I request that the following over the counter (OTC) medications be administered to my child if necessary (**please check medication and circle child's dose**):

**For mild pain, headache, earache, menstrual cramps, muscle aches, fever above 101**

\_\_\_\_\_ **Acetaminophen (TYLENOL) Regular strength 325mg or Extra Strength 500 mg**

**1 or 2 tabs**

\_\_\_\_\_ **Ibuprofen (ADVIL/MOTRIN) 1 or 2 tablets 200mg tab**

**If your child requires liquid or chewable medication please send it to school, we do not stock liquid/chewable medications.**

**For Upset Stomach**

\_\_\_\_\_ **Chewable Antacid tablet (Tums) 1 or 2 tablets**

**For Mild Allergic Reaction and/or Seasonal Allergies**

\_\_\_\_\_ **Diphenhydramine(Benadryl) 25mg 1 or 2 tablets**

\*I understand that the school nurse, with the established orders that have been developed and approved by the Collier School physician along with the written consent of a parent/guardian, can administer the above medications. Be advised that the school shall incur **NO** liability as a result of any injury arising from the administration of medication and the parents/guardians shall indemnify and hold harmless Collier School and its employees or agents against any claims arising out of administration of this medication.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Contact phone number