Pennsauken Public Schools

EMERGENCY INFORMATION VERIFICATION FORM - Part 1

Please sign as indicated. Please fill in any missing information and make corrections where necessary.

Current School:	School Year:	Student ID: (Will be entered by School Staff)	
STUDENT'S Name:		DOB:	Sex:
Legal Residence / Address:		Other Court Ordered / Legal Restrictions: Yes No	
		Court Ordered **CUSTODY** Agreement Yes No	

Please include the company name for Work numbers, so that if your company changes phone numbers we will still be able to locate you. Emergency numbers will only be used in the event that we cannot reach the other numbers listed.

The Primary or CELL Number will also be used for ATTENDANCE AUTO-DIALER

GUARDIAN #1 Full Name:	Primary #:	Cell #:
Relationship to Student:		
EMAIL:	Work/Company Name	Work/Company telephone#:
GUARDIAN #2 Full Name:	Primary #:	Cell #:
Relationship to Student:		
EMAIL:	Work/Company Name	Work/Company telephone#:
EMERGENCY #1 Full Name:	Primary #:	Cell #:
Relationship to Student:		
EMAIL:	Work/Company Name	Work/Company telephone#
EMERGENCY #2 Full Name:	Primary #:	Cell #:
Relationship to Student:		
EMAIL:	Work/Company Name	Work/Company telephone#:
EMERGENCY #3 Full Name:	primary #:	Cell #:
Relationship to Student:		
EMAIL:	Work/Company Name	Work/Company telephone#:

Pennsauken Public Schools

EMERGENCY INFORMATION VERIFICATION FORM – Part 2

Please sign as indicated. Please fill in any missing information and make corrections where necessary.

HEALTH Information:	This student's health information may be shared with pertinent school staff if necessary to maintain well being and safety.
Medical alerts/allergies:	**Parent / Guardian MUST call the school if the student will be ABSENT or Late/Tardy.**
Receives daily medication during school hours? Y / N	
Wears glasses and/or contact lenses: Y / N	**Signature** **Date**

Health care provider information (for emergency treatment when we are unable to contact you):

Contact Type	Contact Name	Contact Number
Hospital		
Doctor		
Dentist		

Does your child have health insurance coverage?	Please sign here to indicate that we have your permission to call the physicians listed or to have your child taken to the hospital when you are not available or in an emergency.
If yes, what is the name of the Insurance Company?	**Signature** **Date**

NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information call 800-701-0710 or visit www.njfamilycare.org to apply online.

You may release my name and address to NJ FamilyCare Program to contact me about health insurance.

Signature **Printed Name** **Date**

For School Use Only:

Student ID: Date filed:

Date Updated in Database: Initials:

PENNSAUKEN PUBLIC SCHOOLS
DEPARTMENT OF SPECIAL SERVICES

HEALTH HISTORY QUESTIONNAIRE

Child's Name_____ Birth Date_____ Gender: male ☐ female ☐

Parent/Guardian Name_____

PERINATAL / BIRTH HISTORY (PreK-6 Only)

Did mother have any problems/illnesses during the pregnancy or birth? Yes ____ No____

If yes, explain briefly_____

_____

Was child born full term _____ early_____ late_____?

What was child's birth weight? _____

Did your child have any illnesses or problems as a newborn?

Yes____ No____ If yes, explain briefly_____

_____

HEALTH CONDITIONS HISTORY

	YES	NO	YEAR
Allergies			
Asthma			
Cardiac (heart) condition/problem			
Chicken Pox			
Diabetes			
Frequent colds			
Frequent Ear Infections			
Frequent headaches			
Frequent nosebleeds			
Frequent stomachaches			
Frequent throat infections			
Hearing Problems			
Hemophilia			
High fever (>104 degrees for 2 days or longer)			
Meningitis			
Seizures			
Sickle Cell Disease			
Toothaches/Dental Problems			
Tubes placed in ears			
Vision Problems			

If yes to any of the above, please describe_____

_____

over

How often is your child sick? often _____ occasionally _____ not often _____

Is your child currently taking any medication? Yes _____ No _____

If yes, please list the name of the medications and how often medication is taken:

Name of Medication	How Often is Medication Taken

Will your child need to take this medication(s) in school? Yes _____ No _____

Has your child ever been hospitalized? Yes _____ No _____

If yes, please explain _____

_____

Are there any additional health concerns that you would like the nurse and/or school staff to be aware of?

_____

_____

_____

Primary Physician:

Name: _____ Phone: _____

Do you have health insurance for your child? Yes _____ No _____

If yes, child's health insurance coverage plan: _____

If no, you may release my name and address to NJ Family Care Program to contact me about health insurance. Yes ____ No ____ Apply online at www.njfamilycare.org or call 800-701-0710

I GIVE PERMISSION TO THE SCHOOL NURSE TO SHARE ANY OF THE ABOVE INFORMATION WITH THE APPROPRIATE SCHOOL PERSONNEL:

Parent/Guardian Signature:_____ **Date:**_____

Revised 10/14

PENNSAUKEN PUBLIC SCHOOLS
MEDICATION POLICY

The following are policy requirements for students requiring medication during school hours:

1. Written orders from the student's doctor for dispensing the medication.
2. Written permission from the parent/guardian.
3. Medication must be in the original container for both prescription and non-prescription medications.
4. No student under age 18 is permitted to carry medication to school. All medication must be transported to and from school by the parent/guardian or a designated adult.

Medications cannot be dispensed unless all of the above requirements are met.

The medication requirements are also outlined in your student/parent handbook for reference.

Please sign, detach and return

MEDICATION POLICY

AGREEMENT

We have read the above requirements and agree to comply with them.

_____ _____

Parent/Guardian Signature Date

_____ _____

Student Name Grade

PENNSAUKEN PUBLIC SCHOOLS
SPECIAL SERVICES DEPARTMENT

PERMISSION FOR SCHOOL HEALTH SERVICES

I hereby give permission for my child, _____,
to receive the following medical attention as part of the school health services program in Pennsauken Public Schools:

1. A Mantoux intradermal test for tuberculosis for specified students as mandated by New Jersey Department of Health and Senior Services.

2. Vision, hearing, height and weight screenings according to New Jersey School Health Services Guidelines.

3. Scoliosis screening by the school nurse or certified trained professionals. All students ages 10 through 18 years of age are required to have this exam in New Jersey every other year.

I understand that I will be notified by the school nurse if any problems are found as a result of these screenings.

I give permission for my child to be taken to _____ Hospital for treatment, in case of emergency, if I cannot be reached.

Parent Signature: _____ Date: _____

Address: _____

Telephone: (HOME) _____

(WORK) _____

(EMERGENCY CONTACT) _____

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 ☐ Male ☐ Female	Date of Birth / /
Does Child Have Health Insurance? ☐Yes ☐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	

I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Signature/Date	This form may be released to WIC. ☐Yes ☐No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:	Results of physical examination normal? ☐Yes ☐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)*	

IMMUNIZATIONS	☐ Immunization Record Attached ☐ Date Next Immunization Due:

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐ None ☐ Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	☐ None ☐ Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☐ None ☐ Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐ None ☐ Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☐ None ☐ Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☐ None ☐ Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☐ None ☐ 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: ☐ Capillary ☐ Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

☐ ***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	

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 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 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 heath 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.

Pennsauken Public Schools

Required Immunization Acknowledgement – Health Forms

Dear Parent/Guardian:

By State law, in order to be enrolled in any school in New Jersey, a complete immunization record must be presented at the time of enrollment. NO **child can be admitted into school without a complete immunization record.** https://nj.gov/health/cd/imm_requirements/

- Students entering Pre-K must have the following immunizations:

DTaP:	4 doses
POLIO:	3 doses
MMR:	at least 1 dose after the age of 1 (12 months)
Varicella:	at least 1 dose after the age of 1 (12 months) unless your child had chicken pox – need to provide school with either: 1. Documented laboratory evidence showing immunity 2. A physician written statement that the child previously had the chicken pox or 3. A parent's written statement that the child previously had the chicken pox
HIB:	at least 1 dose given on or after 1st birthday
PCV:	at least 1 dose given on or after 1st birthday

- Students entering Kindergarten must have the following immunizations:

DTaP:	4 doses with 1 dose given on or after the 4th birthday, or any 5 doses
POLIO:	3 doses with 1 dose given on or after the 4th birthday, or any 4 doses
MMR:	2 doses on or after the 1st birthday
Varicella:	1 dose on or after the 1st birthday
Hepatitis B:	3 doses

- Students entering 6th grade must have the following immunizations:

Meningococcal:	1 dose given no earlier than 10 years of age
Tdap:	1 dose given on or after 11th birthday

- **Seasonal Influenza:** required for those children 6 months through 59 months of age each year. Students must have vaccine by December 31st.

It is the responsibility of the parent/guardian to provide the necessary proof of all required immunizations **before school starts** in September. Over the summer months, proof of immunizations can be dropped off at the student's assigned school for the Nurse & Main Office. If you have a doctor's appointment for your child in September or October, please provide a written note from the doctor stating the date of the appointment and the immunizations(s) to be given.

Parents who register their children over the summer or after school starts in the fall are subject to the same requirements. If you are unsure if your child has received the required immunizations, please check with your child's pediatrician or the school nurse.

****Children who do not have the required immunizations will be excluded from attending school, even if registered.**

I acknowledge that I have read the guidelines relating to the immunization of my child(ren) prior to entering Pennsauken Public Schools.

Parent/Guardian (printed)	Parent/Guardian (signature)	Date
_____	_____	_____