Community
High School

Lyonel Zunz Building
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Phone: 201-862-1796
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www.CommunityHighSchoolnj.org

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Director of Education
Evan Z. Toth, M.A.
Principal
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Assistant Principal

COMMUNITY HIGH SCHOOL
HEALTH INFORMATION PACKET
2025-2026

Please note: This packet contains multiple forms/notices in a stapled set. Please separate the forms that you will need to return to school. **All forms are to be returned to our school nurse.** Thank you.

Please note that participation in interscholastic athletics requires completion and doctor sign off of a number of forms that are included in this packet.

The set includes:

(1) Health Appraisal Questionnaire. This form MUST be returned to the school by all parents prior to the start of the school year.

(2) Universal Child Health Record. **THE SCHOOL MUST RECEIVE IMMUNIZATION RECORDS AND A CURRENT PHYSICAL EXAM OF NEW STUDENTS *PRIOR* TO THE FIRST DAY OF ATTENDANCE.**

(3) Note to Parents summarizing the required forms for students who take prescription medications at school.

(4) Medication guidelines which are used at Community High School.

(5) Authorization to Administer Prescription Medication in School. This is necessary if medication is to be administered during school hours. These forms must be completed by a licensed physician prescribing the medications and requires parent/guardian signature.

(6) Authorization to Administer Prescription Medication Usually Taken at Home. This is necessary when, in rare circumstances, students forget to take a dose of medication usually taken at home or if a snowstorm, unforeseen event, or stoppage of transportation forces students to remain at school beyond school hours. This form must be completed by a licensed physician prescribing the medication and signed by a parent/guardian.

(7) Authorization for Self-Administration or Assisted Administration of Asthma/Epi-Pen Medication. These forms must be completed by a licensed physician and parent if a student must carry an asthma inhaler or an epi-pen.

(8) Authorization for Self-Administration or Assisted Administration of Over-the-counter medicine.

(9) Verification of Quantity of Prescription Medications form.

For New Jersey students, in accordance with N.J.S.A. 18A:40-4, a parent may request that the health appraisal be performed, at no cost to the parent, by the "medical inspector" of the local sending district or, "in lieu thereof… examination of a physician licensed to practice medicine and surgery within the State."

For New York students, as per New York State Education Law (Section 903-905) which provides for a physical appraisal (examination) to be performed at no cost to the parent by the local sending Committee on Special Education (CSE), a copy of *the last health examination* which was performed by the Committee on Special Education must be sent to the Community School, if it has not already been sent, and the top portion of the New Jersey Health History and Appraisal form, the *immunization record,* must be completed and returned to the school, or a copy of a similar immunization form sent.

Please contact the school nurse with any questions at nurse@communityschool.k12.nj.us

Health Appraisal/Parent Questionnaire

TO BE COMPLETED BY PARENT

Student: _____

DOB: _____ Date: _____

Are there any current problems that may affect your son/daughter's education, which, as a parent, you wish the school to note? _____

_____

_____

Are there any special precautions, limitations and/or special alerts that the school should take regarding your son/daughter's health? _____

_____

_____

Does your son/daughter have asthma? ☐ yes ☐ no

Does your son/daughter have any allergies or sensitivities? (Include any food allergies or sensitivities)

_____

_____

Is permission given for your son/daughter to participate in a regular physical education program? (Indicate any restrictions) _____

_____

_____

Is your son/daughter currently on medication? ‡ If yes, please list: _____

_____

‡ (Please be sure to contact the school when this medication is changed or no longer being used.)

Parent Signature _____

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

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	

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The Community School

MEDICATION GUIDELINES

The following medication guidelines will be used at Community High School. These guidelines enable the school nurse to provide the best possible service to your child. According to New Jersey State law, the school nurse may not administer medication unless these guidelines are followed.

1. Whenever possible, medication should be given at home.

2. The first dose of all new medication must be administered at home.

3. In order for medication to be given at school, the medication must be in the original pharmacy container. In addition, a new medication administration form must be completed and submitted to the health office each school year.

4. An adult must bring the medication to school. If the medication cannot be brought to school by a responsible adult, it may be packaged and mailed to Community High School, 1135 Teaneck Road, Teaneck, NJ 07666, Attention: School Nurse. All medication must be picked up by an adult at the end of the school year. NO medication will be sent home with your child.

5. All medications are kept in the Health Office. The School Nurse will notify you in advance when your child's medication is getting low.

6. If your child takes medication in the morning at home, it is important to give it at the same time every day. If your child is coming to school late due to an appointment or a delayed school opening, the morning dosage should be given as usual because the school dose will be given at the time ordered.

7. The Authorization for Self-Administration or Assisted Administration of Medication For Treatment of Asthma form must be completed by you and your physician in order for your child to administer or be administered treatment. If the medication is to be used on an as needed basis, the order should clearly describe the condition under which the drug is to be used.

8. Students who use Epi-pens or asthma inhalers may carry these medications and self-administer provided the relevant authorization for self-administration form for each is properly completed.

9. A few doses of medication usually taken at home may be kept in the health office in the event a student misses their normal dose or has to remain at school for unforeseen circumstances. The Authorization to Administer Medication Usually Taken at Home must be completed by you and your physician.

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July 2025

To: Parent/Guardian

If it is necessary for your child to receive any medication during school hours, school health policy requires that you provide a written request for the administration of the prescribed medication. For this purpose, four such forms are provided here:

(1) for medication regularly taken in school

(2) for medication usually taken at home that might be needed in cases where a student cannot return home for medication

(3) for students who need to carry an asthma inhaler or an epi-pen

(4) for students who require any over-the-counter medication for occasional relief

In all cases, your private physician must provide written orders detailing the diagnosis or type of illness being treated, the name of the medication, dosage, administration route, time of administration and length of treatment. Tylenol and Halls throat drops will be available in the health office for use when necessary.

All medication should be in the ORIGINAL PHARMACY LABELED CONTAINER which will remain in school. By state health guidelines, the medication must be brought to Community High School by a responsible adult. The form provided verifies the amount of any prescription you might be providing the school. The pharmacist should also provide a separate labeled medication supply for home usage. Please review the medication guidelines which will be used at Community High School.

Thank you.

AUTHORIZATION TO ADMINISTER PRESCRIPTION MEDICATION IN SCHOOL

NAME OF CHILD: _____

DATE OF BIRTH: _____

NAME OF MEDICATION: _____

DOSAGE: _____

FREQUENCY GIVEN & DIRECTIONS: _____

_____

PURPOSE OF DRUG: _____

POSSIBLE SIDE EFFECTS: _____

_____

_____

I authorize the School Nurse or her designated substitute in the event she is absent to administer the above medication to my child during regular school hours and at other times when my child is participating in a school related event. I understand that the Community School, school nurse and other school employees shall incur no liability as a result of any injury arising from the administration of this medication; that I will indemnify and hold harmless the Community School, school nurse and other school employees against any claims arising from the administration to my child.

_____	_____
(Signature of M.D.)	(Parent's Signature)
_____	_____
(Address)	(Date)
_____	_____
(Phone No.)	(Physician's Stamp)

This permission is effective for the current school year only and must be renewed annually.

AUTHORIZATION TO ADMINISTER PRESCRIPTION MEDICATION USUALLY TAKEN AT HOME

NAME OF CHILD: _____

DATE OF BIRTH: _____

NAME OF MEDICATION: _____

DOSAGE: _____

FREQUENCY GIVEN & DIRECTIONS (frequency route/time of administration):

_____

_____

PURPOSE OF DRUG: _____

POSSIBLE SIDE EFFECTS: _____

_____

I authorize the School Nurse or her designated substitute in the event she is absent to administer the above medication to my child during school or at school related activities in the event that my child has missed his/her dosage normally taken at home or has had to remain at school due to unforeseen circumstances and/or has been unable to travel home.

I understand that the Community School, school nurse and other school employees shall incur no liability as a result of any injury arising from the administration of this medication; that I will indemnify and hold harmless the Community School, school nurse and other school employees against any claims arising from the administration to my child.

I agree to update this form and to so inform the school whenever my son/daughter's medication needs might change each time when such change might occur during the course of the school year.

_____ _____

(Signature of M.D.) (Parent's Signature)

_____ _____

(Address) (Date)

_____ _____

(Phone No.) (Physician's Stamp)

This permission is effective for the current school year only and must be renewed annually.

Community High School

AUTHORIZATION FOR SELF-ADMINISTRATION OR ASSISTED ADMINISTRATION OF MEDICATION

FOR TREATMENT OF ASTHMA

To be completed by the parent (please print or type):

Child's Name _____ _____ _____
Last *First* *Date of Birth*

_____ _____ _____
Physician's Name *Address* *Phone #*

I request that my above named child, as authorized by the physician below, either be permitted to self-administer or be assisted in the administration of the medicines indicated below by authorized persons at Community High School. I understand and agree in making this request that neither Community High School nor its staff shall incur any liability as a result of any injury/reaction arising from the self-medication or assisted medication, and agree to indemnify and hold harmless the Community School and its employees or agents against any claims arising out of the administration of the medication. This permission is effective for the current school year.

_____ _____ _____ _____
Date *Parent/Guardian Signature* *Home Phone* *Emergency Phone*

The following must be completed by the Physician:

Diagnosis _____

Medication _____

Form _____ Dose _____

If given daily, what time? _____

If PRN _____

Describe indications _____

How soon may it be repeated? _____

List significant side effects _____

Length of time this treatment is recommended _____

Is child authorized to self-medicate? _____

Other information _____

Date _____ Physician's Signature _____
Physician's Stamp

Community School

AUTHORIZATION FOR SELF-ADMINISTRATION OR ASSISTED ADMINISTRATION OF MEDICATION

FOR TREATMENT OF ANAPHYLAXIS WITH EPINEPHRINE (VIA EPI-PEN)

To be completed by the parent (please print or type):

Child's Name _____ _____ _____
Last *First* *Date of Birth*

_____ _____ _____
Physician's Name *Address* *Phone #*

I request that my above named child, as authorized by the physician below, either be permitted to self-administer or be assisted in the administration of the medicines indicated below by authorized persons at Community School. I understand and agree in making this request that neither Community School nor its staff shall incur any liability as a result of any injury/reaction arising from the self-medication or assisted medication, and agree to indemnify and hold harmless the Community School and its employees or agents against any claims arising out of the administration of the medication. This permission is effective for the current school year.

_____ _____ _____ _____
Date *Parent/Guardian Signature* *Home Phone* *Emergency Phone*

The following must be completed by the Physician:

Diagnosis _____

Medication _____

Form _____ Dose _____

Describe indications _____

How soon may it be repeated? _____

List significant side effects _____

Is child authorized to self-medicate? _____

Other information _____

Date _____ Physician's Signature _____
Physician's Stamp

Community High School

AUTHORIZATION FOR SELF-ADMINISTRATION OR ASSISTED ADMINISTRATION OF MEDICATION

FOR THE OVER-THE-COUNTER MEDICINE NOTED BELOW

To be completed by the parent (please print or type):

Child's Name _____ _____ _____
Last *First* *Date of Birth*

_____ _____ _____
Physician's Name *Address* *Phone #*

I request that my above named child, as authorized by the physician below, either be permitted to self-administer or be assisted in the administration of the medicines indicated below by authorized persons at Community High School. I understand and agree in making this request that neither Community High School nor its staff shall incur any liability as a result of any injury/reaction arising from the self-medication or assisted medication, and agree to indemnify and hold harmless the Community School and its employees or agents against any claims arising out of the administration of the medication. This permission is effective for the current school year.

_____ _____ _____ _____
Date *Parent/Guardian Signature* *Home Phone* *Emergency Phone*

The following must be completed by the Physician:

Diagnosis _____

Medication _____

Form _____ Dose _____

If given daily, what time? _____

If PRN _____

Describe indications _____

How soon may it be repeated? _____

List significant side effects _____

Length of time this treatment is recommended _____

Is child authorized to self-medicate? _____

Other information _____

Date _____ Physician's Signature _____
Physician's Stamp

VERIFICATION OF QUANTITY OF PRESCRIPTION MEDICATIONS

To: School Nurse, Community High School

From: _____
Parent Name

Student Name: _____

THIS FORM MUST ACCOMPANY ALL MEDICATIONS/PRESCRIPTIONS

I am providing the school with the following medications and quantities to be administered at the school to be brought to the school by a responsible adult or sent to Community High School by mail, U.P.S. or some other carrier. No students can transport medications to or from school. All proper authorization forms have previously been sent.

Prescriptions/ Medication Names	Quantities Sent	Date Sent	Parent Instructions

Signed: _____
Parent