LACEY TOWNSHIP MIDDLE SCHOOL

A Tradition Of Pride · A Tradition Of Excellence

GREGORY BRANDIS
PRINCIPAL

Welcome to Lacey Township Middle School

Educating Students in Grades 6 – 8

- **All new students** must pre-register on the Lacey Township School District website prior to making an in-person registration appointment in Lacey Township Middle School.
- Pre-registration is located on our website at www.laceyschools.org
- Once the on-line registration is completed, contact the Lacey Township Middle School Main Office located at 660 Denton Ave (609) 242-2100.
- Please bring all required documents and completed forms to your in-person registration appointment.

660 Denton Avenue · Forked River, NJ 08731 · Phone: (609) 242-2100 · Fax: (609) 242-2114
www.laceyschools.org

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REGISTRATION DAY CHECKLIST

Please bring these items with you to your registration appointment. Students are not considered fully registered until all items are submitted.

(√) Check off each item

A	Original Birth Certificate with the raised seal. A copy will be made at your registration appointment.	
B	Four (4) forms of Proof of Residency to include any of the following items: Property tax bill, deed, contract of sale, lease agreement, mortgage voter registration, vehicle registration, license, permit, bank statements, utility bill, credit card bills, phone bill, and cancelled checks with your current Lacey address at the time of your registration meeting.	
C	Must bring appropriate completed Residency Form. This form is available on the Online Pre-Registration Page – Step 5: Residency Forms.	
D	Student Release of Records (completed by parent).	
E	Pre-Participation Physical Evaluation History Form – Physical and Immunizations (completed by Physician; submit along with current immunizations records) *See Required Medical Documents Letter.	
F	Student Medical Concerns Form & Medication Procedure Form (completed by parent, if applicable).	
G	Guardianship/Custody papers if applicable	
H	Application for Free and Reduced Price School Meals (if applicable) This is available on LTSD Website – Department & Programs ~ Food Service (Print, Fill out and Bring to Childs School)	
*	Transfer Card/Release Paperwork from previous school	
*	Service Copies; IEP, 504 for placement purposes	

*For students transferring from a school outside of Lacey Township School district.

Please make every effort to have your paperwork completed for your scheduled appointment time.

LACEY TOWNSHIP SCHOOL DISTRICT
OFFICE OF SPECIAL SERVICES
A Tradition Of Pride · A Tradition Of Excellence

JOSEPH R. BOND
DIRECTOR OF SPECIAL SERVICES

Required Medical Documents

In accordance to NJ State laws, the Lacey Township Board of Education requires that all registrants submit a completed physical examination form and an immunization record before the start of the school year. The physical form must be dated within 365 days from the start of the school year.

Universal Child Health Record Form

1. Physical Examination – completed by physician
   - A current physical should be submitted upon registration
   - If physical was not performed within 365 days from the start of the school year, a new one must be submitted immediately upon completion.
2. Immunization Form – completed by physician
   - A current immunization record must be submitted at registration, regardless of physical exam date.
   - Any subsequent immunization data should also be submitted immediately upon completion

73 Haines Street · Lanoka Harbor, NJ 08734 · Phone: (609) 971-2000 X1021 · Fax: (609) 971-5714
www.laceyschools.org

LACEY TOWNSHIP MIDDLE SCHOOL

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GREGORY BRANDIS
PRINCIPAL

Welcome to Lacey Township Middle School

Request for Student Records

Dear School Administrator:

The following student has been registered in school as of: _____

STUDENT NAME: _____ GRADE: _____

Please forward the following information to us as soon as possible so that we may properly place this student in our school:

Scholastic Records	Transfer Cards
Health Records	Birth Certificate
Test Results	Basic Skills Records
Report Cards	Discipline Records
Grade in Progress	Special Education Records
NJ SMART ID #	Attendance Record
IEP	504

Thank you for your prompt attention to this matter:

I hereby authorize the release of all available information and reports to:

Lacey Township Middle School
660 Denton Ave.
Forked River, NJ 08731

Parent's Name: _____
(please print)

Parent's Signature: _____ Date: _____

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JOSEPH R. BOND
DIRECTOR OF SPECIAL SERVICES

Physical Examination Form Required

Dear Parent or Guardian:

According to the New Jersey Administrative Code 6A:16-2.2; upon enrollment into school, each school district shall require parents to provide medical examination documentation of each student upon 30 days of enrolling in school.

Please submit the documentation as soon as possible. If you have any questions, please reach out to the health office.

- ☐ Will receive a medical examination from home (family physician)
- ☐ Do not have a home (family physician), will require a medical examination from the school physician.

Parent Signature: _____ Date: _____

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Prescribed and/or Over the Counter Medication Procedure

(Including Aspirin, Tylenol, and Ibuprofen)

For any medication your child will take in the school, please observe the following procedure:

1. Prior to any medication being administered by the school nurse, a written document must be received. Physician's document must state:
    a. the diagnosis
    b. name of medication
    c. dosage, frequency, and time medication is to be administered
    d. physician's documentation can be faxed to the school nurse
2. Parental permission for nurse to administer the medication as directed by the physician
3. Medication prescribed 3 times a day should be taken before school, after school, and at bedtime.
4. All medication must be brought to the school nurse in the original pharmaceutical container with the student's name on it.
5. Medications must be stored in a locked cabinet with the nurse's office; students are not to carry medications on their person or keep them in their lockers.

Please notify the school nurse of any existing medical problems. Thank you for your cooperation in this matter.

Authorization for school nurse to administer medications

School _____ School Nurse _____

Student's Name _____ Date _____

Diagnosis _____ Grade _____

Medication _____ Dosage _____

Parent Signature _____ Time _____

Physician Signature _____ Stamp _____

Action to be taken when no licensed individual is available to administer medication: Hold? _____
Asthma inhalers & Epipens ONLY – Can student self-administer and carry medication? _____

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DIRECTOR OF SPECIAL SERVICES

Student Medical Concerns Form

Parent to complete this section:

Student's Full Name _____ School Year _____

Date of Birth _____ Grade _____ School Attending _____

Physician's Name _____

Address _____

_____

Phone _____

My child has the following medical concerns that I wish to make the school nurse aware of:

_____

_____

_____

_____

If your child requires medication to be administered during school hours:

1. Complete the appropriate **Medical Authorization Form** listed on the District website.
2. Provide medication in its **original container**.
3. Prescription medications must have a **pharmacy label**.
4. A parent **must bring medication in person** to the nurse's office. Students are not permitted to carry as per school policy.
5. For students that are permitted by their physician to self-administer their medication, please complete the **Medication Self-Administration Form**.

Signature of Parent _____ Date _____

Return this form directly to the nurse at your child's school

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GREGORY BRANDIS
PRINCIPAL

September, 2022

Dear Parent:

I want to take this opportunity to thank you for your interest in the Lacey Township Middle School Voluntary Drug and Alcohol Testing Program. We believe this program will offer families another tool to identify members of our school community who are in need of help and provide your child with just one more reason to say "no" to drugs and alcohol. We are pleased to announce that the random drug and alcohol testing will begin this month and will continue throughout the school year.

The testing procedure will take place as follows:

1. The testing contractor will randomly select students to be tested.
2. The selected names will be sent to me so I can verify that a permission slip is on file for those students.
3. On the day of testing, a counselor will select the students individually to a testing area in the nurse's office, which will be closed during the testing.
4. A Certified Collection Agent from the testing contractor will oversee the collection of the sample from the student. The student will be given a paper receipt and will return to class.
5. The results of the test will be forwarded to me. In the case of a positive result, you will be contacted by a certified medical review officer to discuss the test results. If necessary, you will receive a follow-up call from me.

Once again, thank you for your participation in this program. If you have received this letter in error and do not want your child to participate in the program or have any other questions or concerns, please feel free to contact me.

Sincerely,
Gregory Brandis, Principal

LACEY TOWNSHIP MIDDLE SCHOOL

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GREGORY BRANDIS
PRINCIPAL

Consent to Participate
Lacey Township Middle School Voluntary
Random Testing for Student Alcohol or Other Drug Use Program

Student Name (Please Print): _____Grade:_____

We hereby consent to permit the above named student to participate in the Middle School Voluntary Random Testing for Student Alcohol or Other Drug Use Program as approved by the Lacey Township School District. In issuing consent, we permit the student named above to undergo random urinalysis testing for the presence of alcohol or other drugs as outlined in district policy.

We understand that a qualified vendor will oversee the collection process.

We understand that any urine samples will be sent only to a certified laboratory for testing and that the samples will be coded to provide confidentiality.

We hereby give consent to the vendor selected by the Lacey Township School District to perform urinalysis testing for the presence of alcohol or other drugs as named in District policy.

We further give permission to the vendor selected by the Lacey Township School District to release all results of these tests to the Medical Review Officer working for the vendor. We understand these results will be forwarded to the Building Principal and will also be made available to us.

We understand that this consent agreement will be in effect for a period of twelve months from the date tested below.

We understand that the urinalysis conducted will include the following substances and be based on the following levels.

Substance	**Screen/Initial Level**	**Confirmation Level**
AMPHETAMINES (CLASS)	500 ng/ml	250 ng/ml
ECSTASY SCREEN	500 ng/ml	250 ng/ml
COCAINE METABOLITES	150 ng/ml	100 ng/ml
MARIJUANA METABOLITE	20 ng/ml	15 ng/ml
OPIATES	300 ng/ml	300 ng/ml
PCP	25 ng/ml	25 ng/ml
BARBITURATES	300 ng/ml	300 ng/ml
BENZODIAZEPINES	300 ng/ml	300 ng/ml
METHADONE	300 ng/ml	300 ng/ml
PROPOXYPHENE	300 ng/ml	300 ng/ml
OXYCODONBOXYMORPHONE	100 ng/ml	100 ng/ml
ALCOHOL, URINE	0.02 ng/ml	0.02 ng/ml

Student Signature:_____Date:_____

Parent Signature:_____Date:_____

This form should be maintained by the healthcare provider completing the physical exam (medical home). It should not be shared with schools. The medical eligibility form is the only form that should be submitted to a school. The physical exam must be completed by a healthcare provider who is a licensed physician, advanced practice nurse or physician assistant who has completed the Student-Athlete Cardiac Assessment Professional Development module hosted by the New Jersey Department of Education.

■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, non-binary, or another gender): _____

Have you had COVID-19? (check one): ☐ Y ☐ N

Have you been immunized for COVID-19? (check one): ☐ Y ☐ N If yes, have you had: ☐ One shot ☐ Two shots ☐ Three shots ☐ Booster date(s) _____

List past and current medical conditions. _____

Have you ever had surgery? If yes, list all past surgical procedures. _____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU (*CONTINUED*)		Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?			
10. Have you ever had a seizure?			
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Unsure**	**Yes**	**No**
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?			
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?			
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?			

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		

MEDICAL QUESTIONS	Yes	No
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle, your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease? **Unsure**		
24. Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (*CONTINUED*)	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		

MENSTRUAL QUESTIONS	N/A	Yes	No
29. Have you ever had a menstrual period?			
30. How old were you when you had your first menstrual period?			
31. When was your most recent menstrual period?			
32. How many periods have you had in the past 12 months?			

Explain "Yes" answers here.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

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This form should be maintained by the healthcare provider completing the physical exam (medical home). It should not be shared with schools. The medical eligibility form is the only form that should be submitted to a school. The physical exam must be completed by a healthcare provider who is a licensed physician, advanced practice nurse or physician assistant who has completed the Student - Athlete Cardiac Assessment Professional Development module Hosted by the New Jersey Department of Education.

PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

PHYSICIAN REMINDERS

1. Consider additional questions on more-sensitive issues.
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height: Weight:		
BP: / (/) Pulse: Vision: R 20/ L 20/ Corrected: ☐ Y ☐ N		
COVID-19 VACCINE		
Previously received COVID-19 vaccine: ☐ Y ☐ N Administered COVID-19 vaccine at this visit: ☐ Y ☐ N If yes: ☐ First dose ☐ Second dose ☐ Third dose ☐ Booster date(s) _____		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

[a] Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

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Preparticipation Physical Evaluation Medical Eligibility Form

The Medical Eligibility Form is the only form that should be submitted to school. It should be kept on file with the student's school health record.

Student Athlete's Name _____ Date of Birth _____

Date of Exam _____

- o Medically eligible for all sports without restriction
- o Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of
- o Medically eligible for certain sports
- o Not medically eligible pending further evaluation
- o Not medically eligible for any sports

Recommendations: _____

I have reviewed the history form and examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings- are on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Signature of physician, APN, PA _____ Office stamp (optional)

Address: _____

Name of healthcare professional (print) _____

I certify I have completed the Cardiac Assessment Professional Development Module developed by the New Jersey Department of Education.

Signature of healthcare provider _____

Shared Health Information

Allergies _____

Medications:

Other information: _____

Emergency Contacts: _____

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**This form has been modified to meet the statutes set forth by New Jersey.*

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	

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.