DEN COUNTY EDUCATIONAL SERVICES COMMISSION
S WHITE HORSE AVENUE
CLEMENTON, NEW JERSEY 08021
856-784-2100
www.camdenesc.org

Dear Parent/Legal Guardian:

Enclosed is the Beginning of the Year Health and Emergency Information for your child. Please fill out each form carefully and completely.

I. **Emergency Information Sheet** – Please complete the entire sheet, sign it and return within two days. When providing emergency contact people, please be sure individual is available to care for your child during the day and that they have transportation to pick up your child. Also, please provide the phone number where we can reach them.

II. **Health Records Update** – Please complete the form with health events that have occurred since June. A record of immunizations recently administered is needed from your health care provider's office in order to update the student's file. Please do not submit copies from your "Baby's Book" which is given to some parents.

III. **Health Screenings Form** – Explains the health screenings provided by your nonpublic school nurse.

IV. **Medication Administration** – If your child requires medication at school then several regulations must be followed. This applies to both prescription and non-prescription (over-the-counter) medications. Please note **NO MEDICATIONS ARE STOCKED** at the school for administration to students. Any medication must be physician-ordered and provided by the parent/legal guardian. Children are not permitted to transport medicine. Parent/legal guardian or responsible adult must transport medications to and from school.

Please refer to the **District Regulations Regarding Medication** included in this packet.

V. **Physician Medication Order Form** – To be utilized and completed at the time a medication is required for your child during the school day. Please use one page per medication. **Please retain this form at home until it is needed.**

Let's have a safe and healthy school year!

Sincerely,

School Nurse

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EMERGENCY MEDICAL INFORMATION

Last Name _____ First _____ Middle _____ Date of Birth _____
Address _____ School _____
City _____ Zip _____ Grade _____
Home Telephone (____) _____ Teacher/ Home room _____

To Parent or Guardian: To serve your child in case of accident or serious illness, it is necessary that you give the following information for emergency calls:

	Name	Address	Telephone
Mother/	_____	Home _____	_____
Legal Guardian		Work Phone _____	Cell Phone _____
Father/	_____	Home _____	_____
Legal Guardian		Work Phone _____	Cell Phone _____

List two neighbors or nearby relatives who will assume temporary care of your child if you cannot be reached.

Name _____ Name _____
Home/ _____ Home/ _____
Address Address
Work Phone _____ Work Phone _____
Telephone: Home _____ Cell _____ Telephone: Home _____ Cell _____ Relationship/
_____ Relationship/ _____
(To Child) (To Child)

Please list other children attending New Jersey Schools (Name, School)

_____ _____
_____ _____
_____ _____
_____ _____

Does child have Health Insurance?

Yes ___ If yes, name of insurance company _____
No ___ 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 the NJ FamilyCare Program to contact me about health insurance.

Signature: _____ **Printed Name:** _____ **Date:** _____
Written consent required pursuant to 20.U.S.C. § 1232g (b)-(1) and 34 C.F.R. 99.30 (b).

List any medical/surgical care your child received during the past year:

_____

Dental Exam (Date) _____ (Braces) _____
Eye Exam (Date) _____ (Contacts) _____ Glasses _____
Allergy _____ _____
kind medications
Allergic Reaction _____ _____
date medications
Immunizations/Tetanus _____ _____
Date type
Restrictions _____
Type

Doctor _____ Telephone _____
Dentist _____ Telephone _____
Hospital _____ Address _____ Telephone _____

I, the undersigned, do hereby authorize officials of New Jersey Public Schools to contact directly the persons named on this card and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency for the health of said child. In the event that physicians, other persons named on this card, or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child.
I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

Signature of Parent(s)/ Guardian(s) _____ Date _____

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HEALTH RECORDS UPDATE

Dear Parent/Legal Guardian:

In an effort to maintain current student health records, updated health information is requested. If your child had a physical examination, surgery, received immunizations, or was placed on long-term medication therapy during the year, please complete and return the form below. Thank you.

Sincerely,

School Nurse

Student Name: _____ Grade: _____

Physical Exam in the last year? ☐ No ☐ Yes Date of Exam: _____

1. Were immunizations given? ☐ No ☐ Yes If yes, please send note from Physician.
2. Physician's name and phone# _____
3. Does your child have asthma? ☐ No ☐ Yes Type: _____
4. Does your child have allergies? ☐ No ☐ Yes To What: _____
5. Does your child wear ☐ Glasses ☐ Contact Lenses ☐ Neither
6. When was your child's last eye exam? _____

SURGERY, ILLNESS, INJURIES (Please be specific)

_____ Date: _____

_____ Date: _____

_____ Date: _____

Medications taken daily: _____
Please list any comments you feel necessary regarding your child's health or behavior:

_____

_____

_____

Signature of Parent/Legal Guardian: _____ Date: _____

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HEALTH SCREENING PERMISSION FORM

Dear Parent/Legal Guardian:

The Camden County Educational Services Commission provides instructional and non-instructional services to participating public school districts in a variety of counties. Listed are the health services to be offered to students this year. Please inform me in writing by September 30th if you do not want your child to receive any or all of these services.

Messages may be left for me at the school office. Thank you.

Sincerely,

School Nurse

- **Blood Pressure, Height and Weight** – Grades K – 12
- **Vision Screening** – Grades K – 6, 8, 10, Students referred by the Child Study Team or at the request of a parent, teacher or self.
- **Hearing Screening** – Grades K – 4, 6, 8, 10, students entering with no record of hearing screening, students at risk for impairment or noise exposure, students referred by the Child Study Team or at the request of a parent, teacher or self.
- **Scoliosis Screening** – Grades 5,7,9 and 11

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MEDICATION ADMINISTRATION IN SCHOOL

DISTRICT REGULATIONS REGARDING MEDICATION

Medication, **prescription, homeopathic and over-the-counter**, shall be administered in school only on a written order by the prescribing physician, along with a written request and a supply of medication from the parent/legal guardian. All medicine must be properly labeled, in the original pharmacy container and brought to school by the parent/legal guardian. Any unauthorized medication found in a student's possession without proper documentation on file, will be taken, held in the school office, and the parent/legal guardian notified. This is for the safety of your child and others.

Medication in general, according to state law, will be administered or taken under the supervision of the school nurse. **Please note, a school nurse may not always be available during school hours to administer medication.** Receipt of a doctor's order and written request from the parent does not guarantee that a medication can be administered during the school day in the nurse's absence.

A medication order is effective July 1 – June 30 of each school year, and must be renewed annually.

In the case of **A POTENTIALLY LIFE-THREATENING CONDITION,** i.e. epinephrine / inhaler usage/pancreatic enzymes, legislation has been passed which allows a student to carry a medication for immediate availability and self-administration; however, this situation **requires that you contact the school nurse.** These medications that may be carried by a student require proper documents to be completed by the student's health care provider and parent. In the case of a student with a potentially life-threatening allergy, with documented history of any actual anaphylactic episode, provision of a **nurse-trained designee** for administration of emergency epinephrine, in the event a nurse is unavailable, is allowable under law; however, certain restrictions apply and you must contact the school nurse.

Fax orders are only accepted in an emergent situation and must be followed with the original order and original physician and parent signatures. No stamped signatures are acceptable.

Sincerely,

School Nurse

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PHYSICIAN MEDICATION ORDER FORM
Signed Original Order Required

Student Name: _____ Grade: _____

*Please provide a separate form for each medication that is to be administered.

PHYSICIAN TO COMPLETE:

Diagnosis: _____

Medication: _____

Dosage: _____ Route: _____ Time: _____

Special Instructions: _____

Precautions/Side Effects: _____

_____ _____
Physician Signature (ORIGINAL – NO SIGNATURE STAMPS, PLEASE) Date

Physician Name: _____

Address: _____

Telephone #: _____

***Please Note: A school nurse may not always be available during school hours to administer this medication.**

- **A medication order is effective July 1 – June 30 of each school year and must be renewed annually.**

I give permission for (name of student) _____ to receive medication at school as prescribed above by Dr. _____.

I WILL BRING THE MEDICATION (PRESCRIPTION OR NON-PRESCRIPTION) TO SCHOOL IN THE ORIGINAL CONTAINER, PROPERLY LABELED AND WILL PICK UP ANY UNUSED MEDICATION.

_____ _____
Parent Signature Date