Phillipsburg School District

50 Sargent Avenue, Phillipsburg, New Jersey 08865

Dear Parents: (Please keep this page for reference)

The school health program in Phillipsburg School District is designed to maintain the physical and emotional well being of all students. To attain this goal, many services are routinely available to all students of the district. However, as with any school program, we are only effective if full cooperation is received from both students and parents.
The following procedures and services are currently in effect:

MEDICATION: Medication can be administered in school ONLY when the nurse has written instructions from the student's physician, including the students name, name of the drug being administered, directions to administer the drug, and the reason the drug has been prescribed for the student. These instructions (doctors' orders) must be renewed every year. Parents must also sign a permission slip for the nurse to administer prescribed medication. **THIS LAW ALSO APPLIES TO ALL OVER THE COUNTER MEDICATIONS, SUCH AS ASPIRIN, TYLENOL, OR ALLERGY MEDICATIONS.** The exception is over the counter eye solutions necessary for daily contact wear, and cough drops individually carried, if identifiable by manufacturer's label.

LEAVING SCHOOL BECAUSE OF ACCIDENT OR ILLNESS: When it becomes necessary for a student to leave school due to accident or illness, a parent/guardian, or their designee, must come to school and sign the student out in the main office. **Please be sure to return the emergency permission form to school indicating person/persons authorized to pick up your child. Leaving from the health room does not constitute an excused absence from school.**

GYM EXCUSES: Students are required to participate in physical education classes unless they have a current doctor's excuse. Please be sure the doctor includes the amount of time that the student will be unable to participate in gym (for example, one week or one month) or any restrictions, including sports, the student may have.

IMMUNIZATIONS: A constant monitoring of the student's immunization status is conducted throughout the year in keeping with New Jersey requirements. If immunizations become due, parents will be notified by letter. The needed immunization must be received within the allotted time span.

HEALTH SCREENINGS BY SCHOOL NURSE: The nurses conduct several health screenings throughout the year. Height, weight, blood pressure, pulse, vision, hearing, and scoliosis screenings are done for selected grades during the year. Parents will be notified if the screenings indicate a need for medical attention.

SCOLIOSIS (Curvature of the spine): New Jersey Law requires all students aged 10 to 18 years old to be examined for scoliosis every other year beginning in 5th grade. Parents will be notified by letter if further evaluation is needed. If you do not want your child examined for any reason, please notify the school in writing within 30 days of receiving this notice.

PHYSICAL EXAMINATION:

- New student physicals, working paper physicals, and sports physicals should be preformed by the students own physician (Medical Home Office).
- In addition to above requirements the State of New Jersey recommends a physical for each student at least once during each of the students developmental stages:
    - Early Childhood (Pre-school through grade 3)
    - Pre-adolescence (Grade 4 through grade 6)
    - Adolescence (Grade 7 through grade 12)
- If your child has had a physical during the year, please send a copy and any immunization updates to the nurses office so that we can document the information on their school health records.

PLEASE COMPLETE THE ENCLOSED EMERGENCY PERMISSION FORM AND STUDENT HEALTH UPDATE. RETURN THEM TO THE NURSING OFFICE IN YOUR CHILDS SCHOOL. PLEASE INCLUDE ANY INFORMATION WE MAY NEED TO MAINTAIN A CURRENT CONFIDENTIAL RECORD.

REV. 6/2017

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Authorization for Obtaining and Sharing Student Health Information.

There are laws that protect the privacy of student health information. At times the school will need to obtain records from your doctor or other health professional. This may include but is not limited to: Immunization Records, Medication Orders, Medical Excuses and Releases, Reports of Medical Examinations. Health information will be restricted to appropriate staff members directly involved in your child's care to avoid any health related problem on a need to know basis. This may include but is not limited to: information related to allergies, medications and serious medical conditions such as asthma, diabetes, seizures.

Student Name:_____ Date of Birth_____

Section 1: Authorization for sharing of health information with appropriate school staff: (complete for all students)

Parent/Guardian Signature_____**Date**_____

Section 2: Authorization for release of medical records from doctor or institution (complete for all students)

Parent/Guardian Signature _____**Date**_____

Section 3: Information Requested by School Nurse/School Physician (only complete when further specific information is needed)

Records to be obtained from:_____

Name of Doctor/Practice/Institution_____

Address:_____

Records to be returned to:

☐ **Early Childhood Learning Center**	459 Center Street, Phillipsburg, NJ 08865
☐ **Phillipsburg Primary School**	1000 Green Street, Phillipsburg, NJ 08865
☐ **Phillipsburg Elementary School**	525 Warren Street, Phillipsburg, NJ 08865
☐ **Phillipsburg Middle School**	200 Hillcrest Boulevard, Phillipsburg, NJ 08865
☐ **Phillipsburg High School**	1 Stateliner Boulevard, Phillipsburg, NJ 08865

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Student Health History and Emergency Contact Form

Identification:

Student Name:_____ Date of Birth_____ Grade_____

Address:_____ Home Phone #_____

Family and Emergency Contact:

Father Name_____work #_____cell #_____

Mother Name _____work #_____cell #_____

Emergency Contacts: must be able to reach school in 30 minutes or less

1. Name_____ Relationship_____

   Home #_____Work # _____ Cell #_____

2. Name_____ Relationship_____

   Home #_____Work # _____ Cell #_____

Doctor Name_____ Phone # _____

Dentist Name _____ Phone #_____

Authorization for Emergency Treatment in School or on Field Trips:

In case of accident or serious illness when I cannot be contacted, I grant permission for emergency treatment and procedures as deemed necessary by the physician AND sharing of any medical information with staff on a need to know basis.

Hospital of Choice for Emergency_____

Parent/Guardian Signature _____Printed Name _____Date_____

Does your child have Health Insurance?

☐ Yes, Name of insurance company _____

☐ No: NJ Family Care provides free or low cost health insurance for uninsured children and certain low income parents. For more information, please call 800-701-0710 or visit www.njfamilycare.org to apply online. My name and address may be released to the NJ Family Care 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).

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IDENTIFICATION:

Student Name: _____Date of Birth_____Grade:_____

Immunizations:

Please submit any new/ updated record not already on file with the school nurse.

Allergies and Dietary Restrictions: Explain all "yes" answers below

Food	Yes	No
If yes, Must have yearly updated "Allergy Action Plan" filed with nurse		
Medication	Yes	No
Bee Sting	Yes	No

Describe reaction (example: rash, difficulty breathing, anaphylaxis

_____

Medications Taken Regularly: Yes No

If medication is to be given in school,
Must have yearly updated "In School Medication Authorization" filed with nurse

List Medications and Reason for Use

_____

_____

General Medical Information Explain all "yes" answers below

Hospitalizations:	Yes	No
Operations:	Yes	No
Major Injuries, Broken/Fracture Bones:	Yes	No

Explain with date and age

_____

Serious Health Conditions Explain all "yes" answers below:

Asthma	Yes	No
Exercise induced asthma	Yes	No
Diabetes	Yes	No
Heart problems/ High blood pressure	Yes	No
Kidney/Bladder problems	Yes	No
Vision/Hearing problems	Yes	No
Seizures/Epilepsy	Yes	No
Muscle/ Bone problems	Yes	No
scoliosis last doctor screening date _____		
ADHD/ Mental health problems	Yes	No
For preschool/elementary school behavior concerns circle below:	Yes	No

Speech difficulty Slow learner Bowel/bladder accidents
Temper tantrums Overactive Inattentive Shy
Fears: noises crowds school animals strangers darkness

Have there been any events in your child's life that may affect learning? Yes No
(example death, divorce)_____

Family Social/Health History:

Does anyone smoke in the house Yes No

Please list names and ages of household members

Please explain any family health history that you would like to notify us of:

PHILLIPSBURG SCHOOL DISTRICT IN SCHOOL MEDICATION AUTHORIZATION

Main Number: (908)454-3400
Early Childhood Center Ext. 3020 (Fax: 908-213-2821)
Phillipsburg Primary School Ext. 4020 (Fax: 908-213-2552) **Phillipsburg Elementary School Ext. 5020** (Fax: 908-213-2546)
Phillipsburg Middle School Ext. 6020 (Fax: 908-213-2414) **Phillipsburg High School Ext. 7020** (Fax: 908-777-3980)

New Jersey state law requires a written statement from a physician when a student needs to take a prescription or over the counter medication during school hours. ***Medication orders are only effective for the current school year.*** Medications must be in the original prescription container labeled by the pharmacy or in the original over the counter container.

MEDICATION CANNOT BE DISPENSED IN SCHOOL UNTIL A WRITTEN ORDER IS RECEIVED FROM YOUR CHILD'S PHYSICIAN.

Policy Regarding Self-Administration of Medication

Only those students who have *asthma and other potentially life threatening illnesses* are permitted to carry and self-administer inhaled or injectable medication for the treatment/prevention of symptoms. They must be sufficiently responsible and properly educated by their physician and parent/guardian.

After self-medicating with an inhaler for symptomatic wheezing/shortness of breath, the student is strongly encouraged to report to the School Nurse to have an assessment to determine effectiveness of the medication.

Students self-medicating with an Epi-Pen must report to the School Nurse.

Students with *food allergies* must submit a separate Allergy Action Plan from their physician.

Student's Name: _____ Diagnosis: _____ Grade: _____ DOB: _____

Parent/Guardian: _____ Home Phone: _____ Work Phone: _____

MEDICATION	DOSAGE / ROUTE	FREQUENCY/ INDICATION	SIDE EFFECTS

Student may carry medication: YES NO Student may self-administer medication: YES NO

On class trips: As ordered Omit Adjust Schedule _____ On ½ days: As ordered Omit Adjust Schedule _____

Asthma Action Plan and Emergency Asthma Policy

A separate Asthma Action Plan should only be submitted if the physician does not agree.

- If a student presents with wheezing/shortness of breath, prescribed medication will be given.
- Students showing marked improvement after 10 min. post-treatment observation will be permitted to return to class.
- If a student DOES NOT show marked improvement after one dose of medication, parent will be called to pick up student and seek physician care.
- Up to two (2) additional treatments will be given at 20 minute intervals while awaiting arrival of parent.
- If condition worsens, 911 will be called.

_____ _____ _____

Physician's Signature Physician Phone # Date

As the parent / guardian of this student, I request he or she be allowed to receive the medication prescribed above. I hereby agree to indemnify and hold harmless the Phillipsburg School District, it's agents and employees from any and all liability should any injury occur as a result of the administration of the medication.

_____ _____ _____ _____

Parent / Guardian Signature Date School Physician Signature Date

Revised 8/16