



# The Academy of Our Lady of Peace

99 South St. New Providence, NJ 07974

908 464 8657

Dear Parents:

Attached you will find a Student Health form, a parental permission form and medication forms. These forms must be completed and returned before the start of the school year. Please do not send these forms with your child. Please note that the Student Health forms must be completed by your family physician, including all immunizations. Below is a list of instructions.

- **Student Health form** (Please do not use physician's own form, our form must be completed); physical exam must be within 1 yr. prior to the start of school.
- **Parental Permission form**-please sign and return.
- **Immunizations required:**
  - **DPT/DTaP**; a minimum of four doses are required with one dose given on or after the 4<sup>th</sup> birthday.
  - **IPV**; a minimum of three doses with one dose given on or after the 4<sup>th</sup> birthday.
  - **MMR**; one dose on or after the 1<sup>st</sup> birthday; a second dose of measles containing vaccine is required when entering kindergarten.
  - **HIB**; one dose is required prior to beginning Kg or Pre-k.
  - **HEP B**; students must receive three doses of HEP B prior to entering Kindergarten or Grade 1, whichever comes first. If the student was born after January 1, 1990 and is entering grade 6, documentation of three doses of HEP B are required (or 2 doses of adolescent/adult formulation).
  - **Varicella (Chicken Pox) vaccine**; one dose given on or after 1<sup>st</sup> birthday is required for students entering Pre K, Kindergarten or Grade 1 OR Parental/Physician history of disease OR laboratory evidence of immunity.
  - **Pneumococcal conjugate vaccine (PCV)**; as of Sept. 2008 any student attending preschool must have received at least one dose of PCV on or after their first birthday.
  - **Influenza vaccine**; as of Sept. 2008 any student attending preschool shall annually receive at least one dose of influenza vaccine between Sept. 1 and Dec. 31 of each year.
  - **Meningococcal vaccine**; as of Sept. 2008, any student born on or after Jan. 1, 1997 and entering or attending grade 6 must receive one dose of a meningococcal - containing vaccine. Please note: this also applies to students when they turn 11 years of age and are attending grade 6.
  - **Tdap vaccine** (Tetanus, diphtheria, acellular, pertussis); as of Sept.. 2008, any student born on or after Jan. 1, 1997, and entering or attending grade 6 must receive one dose of Tdap given no earlier than the 10<sup>th</sup> birthday. Students who receives a Td (tetanus, diphtheria) booster dose less than 5 years prior to grade 6 shall not be required to receive a Tdap dose until 5 years have elapsed from the last DTP/DTaP or Td dose.
- \*\* All required immunizations must be given prior to the first day of school unless otherwise noted or if your child has a medical or religious exemption on file.
- **Medication forms**- this is required to be completed and signed by both the family physician and the parents if the child requires medication during the school day. One form must be completed for each medication, including any prescribed and/or over the counter medications. No child is to carry medication to school. This is New Jersey State law. If your child will be taking any medications, the parent must bring the medication to school and give it to the main office with the medication forms. If your child will need an inhaler at school, please check the expiration date on the inhaler before bringing it into school to check if it has expired.
- \*\* All medication must be sent to school in the original container with the instructions on it.

Please read over all forms carefully after your doctor's office has completed them, to be sure your child is up to date and in compliance with the state regulations.

If you have any questions, please feel free to call me at the Health office, (908)464-8657 ext. 36. If I'm not in, please leave a message and I will call you back as soon as possible. Thank you in advance for your anticipated cooperation in this matter.

Sincerely,

Patty Miller, R.N.

Revised February 2009

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## STUDENT HEALTH RECORD

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_

Date of Birth \_\_\_\_\_ Birthplace \_\_\_\_\_

Parent/Guardian \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Work/ Cell \_\_\_\_\_

Full Address \_\_\_\_\_

Previous School Attended \_\_\_\_\_

## EMERGENCY PHONE NUMBERS

Father Business Phone \_\_\_\_\_ Cell \_\_\_\_\_

Mother Business Phone \_\_\_\_\_ Cell \_\_\_\_\_

Other \_\_\_\_\_ Cell Phone \_\_\_\_\_

## EXAMINATION

Date of Exam \_\_\_\_\_

1. Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_ Pulse \_\_\_\_\_ bpm Vision R \_\_\_\_\_ L \_\_\_\_\_

2. List physical or emotional disabilities (include speech, hearing, vision)

\_\_\_\_\_  
\_\_\_\_\_

3. Birth or Acquired Abnormalities:

\_\_\_\_\_

4. Chronic Disorders: Diseases of heart, lung, digestive system, nervous system, urinary tract, blood, etc.

\_\_\_\_\_

5. Specific Disorders: List if student has ever had: asthma, sickle cell disease, hemophilia, hernia, enlarged spleen, diabetes, convulsions, high blood pressure.

\_\_\_\_\_

6. Health Aids: List if student wears eyeglasses, contact lenses, hearing aids, braces.

\_\_\_\_\_

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7. Scoliosis Exam: Negative \_\_\_\_\_ Positive \_\_\_\_\_

8. Should activities be limited for any reason? \_\_\_\_\_  
\_\_\_\_\_

9. Can student participate in sports? If no, please explain \_\_\_\_\_  
\_\_\_\_\_

10. Injuries? (Dates) \_\_\_\_\_

11. Operations? (Dates) \_\_\_\_\_

12. Allergies? (List) \_\_\_\_\_

13. Medications: list all prescription medications taken regularly: e.g. insulin, inhalers, tablets, capsules, injections, etc.  
\_\_\_\_\_  
\_\_\_\_\_

14. Immunizations Required by New Jersey State Law: please be sure to include: month/day/year for each immunization.

DTaP/DTP #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_ #4 \_\_\_\_\_ #5 \_\_\_\_\_

Td \_\_\_\_\_ or Tdap \_\_\_\_\_

IPV #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_ #4 \_\_\_\_\_

MMR #1 \_\_\_\_\_ #2 \_\_\_\_\_ Menactra \_\_\_\_\_

Chicken Pox Disease \_\_\_\_\_ or Vaccine \_\_\_\_\_ Influenza \_\_\_\_\_

HIB #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_ #4 \_\_\_\_\_

Hepatitis B #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_

PCV #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_ #4 \_\_\_\_\_

Mantoux Test: Date given: \_\_\_\_\_ site: \_\_\_\_\_ (if applicable)

Date read: Negative \_\_\_\_\_ Positive \_\_\_\_\_

\_\_\_\_\_  
Physician Signature & stamp

\_\_\_\_\_  
Date  
Of Exam

\_\_\_\_\_  
Office Number

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**CLEARANCES: (See notes at bottom for conditions requiring attention and for a list of sports by level of contact)**

- A. Student is cleared for participation in all sports without restriction.
- B. Student is **withheld clearance** for participation in any sport until evaluation / treatment of:  
\_\_\_\_\_
- C. Student is cleared for participation in **limited types** of sports which **exclude** the following types of sports contact: (CHECK ALL THAT APPLY)
  - \_\_\_ CONTACT/COLLISION
  - \_\_\_ LIMITED CONTACT
  - \_\_\_ NON-CONTACT/STRENUOUS
  - \_\_\_ NON-CONTACT/NON-STRENUOUS
 Due to: \_\_\_\_\_

HISTORY REVIEWED AND STUDENT EXAMINED BY:

Physician's/Provider's Stamp:

- Primary Care Provider
- School Physician Provider
- License Type:
  - MD/DO
  - APN
  - PA

PHYSICIAN'S/PROVIDER'S SIGNATURE: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Date of Exam: \_\_\_\_\_

HISTORY REVIEWED BY:  
Name \_\_\_\_\_ Today's Date: \_\_\_\_\_  
SIGNATURE: \_\_\_\_\_ Review Date: \_\_\_\_\_

**NOTES TO THE EXAMINING PROVIDER**

Conditions requiring clearance before sports participation include, but are not limited to the following:

Anaphylaxis; Atlantoaxial instability; Bleeding disorder; Hypertension; Congenital heart disease; Dysrhythmia; Mitral valve prolapse; Heart murmur; Cerebral palsy; Diabetes mellitus; Eating disorders; Heat illness history; One-kidney athletes; Hepatomegaly; Splenomegaly; Malignancy; Seizure Disorder; Marfan Syndrome; History of repeated concussion; Organ transplant recipient; Cystic fibrosis; Sickle cell disease; and/or One-eyed athletes or athletes with vision greater than 20/40 in one eye.

SAMPLES OF CLASSIFICATION OF SPORTS BY CONTACT			
Contact/Collision	Limited Contact	Non-Contact	
		Strenuous	Non-strenuous
Basketball	Baseball	Discus	Bowling
Diving	Cheerleading	Javelin	Golf
Field Hockey	Fencing	Shot put	
Football	High Jump	Rowing	
Ice Hockey	Pole vault	Running/Cross Country	
Lacrosse	Gymnastics	Strength Training	
Soccer	Skiing	Swimming	
Wrestling	Softball	Tennis	
	Volleyball	Track	

N.J.A.C. 6A:16-2.2 requires the school physician to provide written notification to the parent/legal guardian stating approval or disapproval of the student's participation in athletics based on this physical evaluation. This evaluation and the notification letter become part of the student's school health record.



## Parental Permission Form

2010-2011 Academic Year

Name of Student \_\_\_\_\_ Grade: \_\_\_\_\_

The law requires that parental permission and physician approval be obtained for procedures on minors. The following consent form should be signed by the parents or guardian so that such procedures may be promptly carried out.

“IN CASE OF ACCIDENT OR SERIOUS ILLNESS, I REQUEST THE SCHOOL TO CONTACT ME. IF THE SCHOOL IS UNABLE TO REACH ME, I THEREBY AUTHORIZE THE SCHOOL TO CALL THE PHYSICIAN INDICATED BELOW AND TO FOLLOW HIS INSTRUCTIONS. IF IT IS IMPOSSIBLE TO CONTACT THIS PHYSICIAN, THE SCHOOL MAY MAKE WHATEVER ARRANGEMENTS DEEMED NECESSARY.”

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Parent/ Guardian (PRINT)

Local Physicians Name: \_\_\_\_\_

Office Phone Number ( \_\_\_\_\_ ) \_\_\_\_\_

Local Dentist's Name: \_\_\_\_\_

Dentist Office Phone Number: ( \_\_\_\_\_ ) \_\_\_\_\_

Please return to the Health Office



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Dear Parent/Guardian:

Parental consent is required for the release of all medical information that is to be shared with school personnel. The consent form must be updated yearly. Please return this completed form to the School Nurse by the first day of school.

Thank you,

Patty Miller, RN  
School Nurse

## AUTHORIZATION FOR EXCHANGE OF CONFIDENTIAL INFORMATION

**Student:** \_\_\_\_\_

**Grade:** \_\_\_\_\_

As Parent/Guardian of the above named student, I hereby authorize the release of pertinent medical information (medical conditions, allergies, and/or medication regimes) to be exchanged among the appropriate professional staff involved in the care of the above student. This consent is valid for the 2010 - 2011 school year and is intended to allow the staff to better serve my child.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date



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## AUTHORIZATION TO ADMINISTER MEDICATION IN SCHOOL (Confidential upon Completion)

NAME OF STUDENT: \_\_\_\_\_ GRADE: \_\_\_\_\_

DIAGNOSIS/ILLNESS: \_\_\_\_\_

MEDICATION: \_\_\_\_\_

DOSAGE: \_\_\_\_\_ FREQUENCY: \_\_\_\_\_

SPECIAL DIRECTIONS: \_\_\_\_\_

POSSIBLE SIDE EFFECTS: \_\_\_\_\_

I CERTIFY THAT THE ABOVE INFORMATION REGARDING THIS STUDENT IS CORRECT, AND THAT ADMINISTRATION OF THE MEDIATION TO THIS STUDENT IS NECESSARY.

\_\_\_\_\_  
SIGNATURE OF PRESCRIBING PHYSICIAN

\_\_\_\_\_  
DATE

\_\_\_\_\_  
ADDRESS OF PHYSICIAN

\_\_\_\_\_  
PHONE NUMBER

I/ WE AUTHORIZE THE SCHOOL NURSE, THE PRINCIPAL, OR THE PRINCIPAL'S DESIGNEE, TO ADMINISTER THE ABOVE MEDICATION AS INDICATED. I/WE UNDERSTAND AND AGREE THAT THE SCHOOL NURSE, THE PRINCIPAL, OR THE PRINCIPAL'S DESIGNEE, SHALL NOT BE LIABLE FOR ANY INJURY TO THE STUDENT FROM THE ADMINISTRATION OF THE MEDICATION AS AUTHORIZED BY MY SIGNATURE BELOW.

\_\_\_\_\_  
Signature of Parent /Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Parent /Guardian (PRINT)

\* One form must be completed for each medication to be administered at school, including Tylenol.

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