Franklin Township School Emergency Care Form

PLEASE COMPLETE ALL INFORMATION BELOW:

Student's Name_____ Home Phone _____

Address_____ Please check if this ☐ is a new address

(Please notify the school if the above address changes during the school year)

Grade _____ **Teacher's Name** _____ **Date of Birth** _____

Please list telephone numbers at which parents can be reached.

1. _____ **2.** _____

Cell Phone Numbers:

Parent I Cell: _____ **Parent II Cell:** _____

Parent I Work: _____ **Parent II Work:** _____

EMAIL ADDRESS(ES) _____

Please list name and telephone number of two people whom we may contact in case your child becomes ill and we can't contact you.

1. _____ Phone_____

2. _____ Phone_____

List of any known allergies:_____

Please list any current health problems:_____

Is medication required: Yes_____ No_____

Does your 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 please 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).

Please indicate in the space below if there has been a divorce or separation since the previous school year. If there has been a divorce or separation and the non-custodial parent cannot sign the child out of school, legal documentation must be provided.

***PLEASE BRING CUSTODY PAPERS TO BE KEPT ON RECORD (CONFIDENTIAL)**

No Change in Marital Status _____ Divorce _____ Separation _____

Non-Custodial Parent May _____ May Not _____ sign child out of school.

In case of an accident or serious illness, I request the school to contact me. It will be the parent/guardian responsibility to come to the school for the child. If the school is unable to reach me, I hereby authorize the school to call the physician indicated below and to follow his/her instructions. If it is impossible to contact this physician, the school may make whatever arrangements are necessary for the welfare of my child. I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

FAMILY DOCTOR _____Phone_____

I have carefully read and understand the attachment explaining the school's EARLY ALERT PROGRAM. By affixing my signature below & by providing the appropriate information, I agree to be bound by the terms of the EMERGENCY CARE AND EARLY ALERT procedures.

_____ _____

Date Parent's Signature

(over)

AUTHORIZATION FOR ADMINISTRATION OF OVER THE COUNTER MEDICATION IN SCHOOL FOR ACUTE ILLNESSES

Our School Medical Inspector, Ronald M. Frank, MD has authorized the administration of the following medications by the School Nurse in the School Health Office. However, parental/guardian permission is required before a student can receive any of the listed medications. If you would like your child to be able to receive any of the listed medications in school if needed, please complete the following and return it to the Health Office. Students will receive only ONE DOSE during the school day.

The following section is to be completed by the PARENT/GUARDIAN:

_____ _____

Student's Name Date

I request that my child be assisted in taking the medication described below at school by the School Nurse or other individuals authorized to administer medication to students in school pursuant to N.J.A.C.: 6A: 16-2 3. I understand the ultimate responsibility for administration of the medication is mine and I am fully aware that the duties of the School Nurse and others may require their presence at another location at the time that the medication is needed. I understand that the school district, agents and its employees shall incur no liability as a result of any condition or injury arising from the administration or lack of administration of the medication prescribed on this form. I indemnify and hold harmless the School District, its agents and employees against any claims arising out of administration or lack of administration of this medication.

I authorize the administration of (check all that apply):

☐ Acetaminophen dosed according to weight and product label.

☐ Ibuprofen dosed according to weight and product label.

☐ TUMS® dosed according to product label.

Signature (parent/guardian):_____

Printed Name:_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____

RECOMMENDATIONS ARE EFECTIVE FOR ONE (1) SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY.

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.

Medical History Form – New Student Registration

Student Name: _____ Date of Birth: _____

1. Your Child
   a. Pregnancy & Birth
      Birth Weight: _____ Full-Term Premature
      Describe any problems during pregnancy and/or birth:
   b. Developmental Milestones
      Age for Walking: _____ Talking: _____ Toileting: _____
      Describe eating habits: _____
      Describe sleeping habits: _____
      Describe difficulties during preschool years: _____
   c. Physical – Has/Does your child have any of the following? (Indicate Yes or No Below. If yes, explain in further comments.)

Hospitalizations		
Operations	Yes	No
Illness	Yes	No
Allergies	Yes	No
To: _____		
Allergic Reactions	Yes	No
Medications	Yes	No
Foods	Yes	No
Other _____	Yes	No
Asthma	Yes	No
On Medication	Yes	No
Bronchitis	Yes	No
Pneumonia	Yes	No
Finger/Thumb Sucking	Yes	No
Frequent Colds	Yes	No
Coordination Concerns	Yes	No
Bleeds Easily/Excessive	Yes	No
Dental Problems	Yes	No
Elimination		
Bed Wetting	Yes	No
Constipation	Yes	No
Diarrhea	Yes	No
Daytime Incontinence	Yes	No
Wears Pullups	Yes	No
Endocrine/Diabetes	Yes	No
Frequent Earaches	Yes	No[1]
Hearing Loss	Yes	No
Ear Tubes	Yes	No
Emotional Concerns	Yes	No
Headaches	Yes	No

Joint Pain, Swelling, Limping	Yes	No
Muscular/Skeletal/Accident Prone	Yes	No
Frequent Sore Throats	Yes	No
Skin Problems/Concerns	Yes	No
Speech Problems/Concerns	Yes	No
Seizures	Yes	No
Medications	Yes	No
Vision		
Problems/Concerns	Yes	No
Sees an Eye Doctor	Yes	No
Wears Glasses/Contacts	Yes	No
Worms/Parasites	Yes	No
Ever Passed Out/Unconscious	Yes	No
Prone to Nosebleeds	Yes	No
Tires Easily	Yes	No
Developmental Disabilities	Yes	No
Takes Medication Daily	Yes	No
Medication Name _____		

Further Comments:

   d. Inner Self

Excessive Shyness	Yes	No
Temper Tantrums	Yes	No
Persistent Crying	Yes	No
Nail Biting	Yes	No
Social with Peers	Yes	No

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2. Your Family
   a. Family Members

Relationship	Birthdate	Name
Mother	XXXXXXX	_____
Father	XXXXXXX	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

   b. Medical History (Indicate Yes or No if immediate family members have history, as listed below)

Sudden Cardiac Death	Yes	No	Heart Disease	Yes	No
Allergies	Yes	No	High Blood Pressure	Yes	No
Asthma	Yes	No	Development Disability	Yes	No
Bleeding Disorders	Yes	No	Mental Health Illness	Yes	No
Vision Disorder	Yes	No	Lead Poisoning	Yes	No
Cancer	Yes	No	Seizures	Yes	No
Hearing Disorder	Yes	No	Tuberculosis	Yes	No
Diabetes	Yes	No	Kidney Disease	Yes	No
Drug/Alcohol Addiction	Yes	No			

Please note the relative for any Yes, above: _____

Further Comments/Information

Parent Signature: _____ Date: _____