WASHINGTON ACADEMY
STUDENT HEALTH INFORMATION PACKET

SCHOOL NURSE:
PHONE: 973-239-6555 Ext: 204
FAX: 973-239-6335

A COPY OF YOUR CHILD'S IMMUNIZATION RECORD MUST BE FORWARED TO THE HEALTH OFFICE PRIOR TO ADMITTANCE

THE FOLLOWING IS NECESSARY FOR YOUR CHILD'S ATTENDANCE:

1. COPY OF THE MOST UP TO DATE IMMUNIZATION RECORD

2. COPY OF MOST RECENT PHYSICAL & DENTAL EXAM (MAY USE PAGE 3 OF THE SPORTS PHYSICAL FORM PROVIDED)

3. COMPLETION OF GENERAL MEDICAL INFORMATION FORM PROVIDED

4. PLEASE CONTACT THE SCHOOL NURSE IMMEDIATELY FOR INSTRUCTIONS IF YOUR CHILD HAS ANY OF THE FOLLOWING:

    *ASTHMA
    *HISTORY OF SEIZURES
    *FOOD or MEDICATION ALLERGIES
    *REQUIRES AN EpiPen FOR SCHOOL
    *REQUIRES MEDICINE DURING SCHOOL HOURS
    *OTHER MEDICAL CONCERNS

<u>NO MEDICINE</u>, OTHER THAN INHALERS OR EpiPens (<u>WITH DOCTOR'S ORDERS</u>), MAYBE BE BROUGHT TO SCHOOL BY YOUR CHILD AT ANY TIME

Washington Academy
STUDENT MEDICAL INFORMATION

Student:_____ Parent/Guardian:_____

Student Date of Birth:_____ Address:_____

Home Phone:_____ Cell:_____ Work:_____

List allergies to medication and food below:_____
_____

Is the allergy life-threatening requiring an Epi-pen? _____

Is your child allergic to bee-stings?_____ Is it life-threatening?_____

Does your child have Asthma?_____ Does your child use an inhaler? _____

If Yes, please explain under what circumstances:_____
_____
**If yes, an Asthma Action Plan and physician order are required for school. Please contact the school nurse.

If your child has been diagnosed with any of the following, please circle below:

HEART CONDITION	BLOOD DISORDER	BLADDER/BOWEL PROBLEMS	DEPRESSION
LUNG CONDITION	CANCER	HIGH/LOW BLOOD PRESSURE	ADHD
SKIN CONDITION	EYE/EAR PROBLEMS	NEUROLOGICAL CONDITION	ADD
SEIZURE DISORDER	DIABETES	BI-POLAR DISORDER	

OTHER (EXPLAIN)_____

Pediatrician/Attending Physician_____ Phone:_____

Address:_____

Month/Year Child's last Well Exam _____ *Please forward a copy of the findings with most recent immunization and have your doctor use the sports-physical form to document your child's exam.

Psychiatrist/Therapist_____Phone:_____

Address:_____

Does your child take any prescription medicine at home? If yes, names & dosage below:
1.) _____ 2.) _____ 3.) _____

Is the medication needed during school hours?_____
(If yes, please contact the school nurse immediately at 973-239-6555 for policy)

Any special consideration for your child?_____

*** As the parent/guardian of _____, I hereby authorize the
STUDENT NAME
medical staff of Washington Academy to obtain first-aid for the above named child by way of the 911 emergency access system. I understand that in the event of an emergency, my child will be sent to the nearest hospital facility and so I authorize the release of all medical and contact information to all emergency responders. I also authorize the school nurse to confer with my child's personal physician and school physician as it is deemed necessary. I understand that it is my responsibility to pick my child up from school for illness or meet my child at the nearest hospital facility if necessary. My signature below indicates that I understand and will comply with the above as stated.

_____
Parent/guardian signature

Jack Schwartz, Ph.D
Executive Director

David Schwartz, MA
Director

Authorization for Exchange of Confidential Information

Student_____ Parent/Guardian_____

Date of Birth _____ Grade_____

As parent/guardian of the above named student, I hereby authorize the exchange of pertinent educational and medical information (i.e. medical conditions, allergies, and/or information regarding my child's medications) among the appropriate professionals involved in the care of the above named student. For the purposes of this consent the reference to "professionals" may include my child's; pediatrician, psychiatrist, behavioral therapist, occupational, speech and/or physical therapist, teachers, school administrators and all child study team members.

In doing so I realize that such an exchange may require the fax transmission of sensitive material and that as a result, the staff of Washington Academy will not incur any liability. I also recognize that such action is executed with the intent to provide my child with the continuity of care necessary to maintaining an educational record that is current and appropriate to my child's needs (i.e academic, medical, emotional and social).

This consent is valid for the **2011-2012** school year and is intended to allow the staff at Washington Academy to better serve my child.

_____ _____

Date **Signature of Parent/Guardian**

Jack Schwartz, Ph.D
Executive Director

David Schwartz, MA
Director

Medical Report

Child's Name: _____ Sex:_____ DOB: _____

Address: _____

Height: _____ Weight: _____ B/P: _____ Heart: _____

Skin: _____ Lungs:_____

Eyes: _____ Orthopedic: _____

Vision: _____ Right: _____ Left: _____ Posture: _____

Ears: _____ Nutrition: _____

Hearing: _____ Hernia: _____

Nose: _____ Nervous System: _____

Throat: _____ Other: _____

Operations or Accidents: _____ Date: _____

Allergies: _____

Communicable Diseases: _____ Date: _____

Mantoux Date: _____ Result: _____

Other Medical or emotional problems – Is there any condition which we should know about which would give us a better understanding of the child's general health? Is there any reason for limited physical education? If so, what limitations are advised and for what reasons?

_____
_____
_____

_____ _____

Signature of Family Physician **Date of examination**

COMPLETION OF THIS FORM BY THE PARENT AND PHYSICIAN IS REQUIRED:

PERMISSION FOR SELF-ADMINISTRATION OF MEDICATIONS

_____ _____

Name of Student (print) **Grade**

EPIPEN AND INHALER INSTRUCTIONS ***(complete if applicable)***

I have instructed the above student in the use of his/her epipen or inhaler and he/she may be permitted to carry the medication on his/her person and self-administer it as instructed by me.

_____ _____ _____

Physician (Print) Physician (signature) Date

Recommendations are effective for one school year only and must be renewed annually. All forms must be received and be on file in the health office before any medication can be administered.

REQUEST FOR SELF-ADMINISTRATION OF EPIPEN OR INHALER

I request that my child be permitted to carry and self-administer his/her epipen or inhaler at school, as authorized by my physician above. I accept full responsibility for making sure that my child carries the drug at all times. I release the district and its employees from any liability as a result of an injury arising from the self-administration of this medication.

_____ _____ _____ _____

Parent's Signature Date Home Phone Emergency Phone

INDEMNIFICATION/HOLD HARMLESS AGREEMENT FOR SELF-ADMINISTRATION OF MEDICATION

The parents(s)/guardian(s) agree(s) to indemnify, defend and hold the school district harmless from any and all claims, action, costs expenses, damages and liabilities, including attorney's fees arising out of, connected with or resulting from the self-administration of medication by the pupil. The parent(s)/guardian(s) agree(s) to extend this indemnification/hold harmless agreement to the Board of Education, Board of Education employees and its agents. The parent(s)/guardian(s) agree(s) the school district, Board of Education, Board of Education employees and its agents shall incur no liability as a result of any injury arising out of or connected with the self-administration of medication by the pupil.

The agreement shall take effect on the date listed below and shall stay in effect for as long as the pupil is provided permission to self-administer medication. This agreement must be signed and in full effect to the granting of permission to self-administer medication.

_____ _____ _____

Student Name Print Parent Name Parent Signature

_____ _____ _____

Building Principal Print Parent Name Parent Signature

FOR SCHOOL USE ONLY

Approved by the School physician: _____ _____

School Physician (Signature) Date

Washington Academy
520 Pompton Avenue
Cedar Grove, NJ 07009-1611

Tel: 973-239-6555
Fax: 973-239-6335

Request to Administer Medication in School for **September 2011 – August 2012** school year

Completion of this form by your physician will enable the school nurse to medicate your child in school. The administration of medicine to students by the school nurse should only be done in circumstances wherein the student's health or ability to function in school may be jeopardized without it. The medication must be presented in the original bottle and properly labeled from the pharmacy. Please note that by signing this form you are also granting the school nurse the right to confer with your physician whenever necessary. No prescription or OTC medications are to be brought to school without a physician's order. A new form must be completed every time there is a change in the child's dosage or medication. The nurse reserves the right to withhold medication at any given time if this policy is not strictly adhered to.

Attach copy of original prescription here

PHYSICIAN MUST COMPLETE THIS SECTION

Student Name_____

Allergies_____

Medication_____

Dosage/Route of Administration_____

Time to be given at school_____

Times given at home_____

Purpose_____

Possible Side Effects_____

Physician Comments_____

Physician Signature_____

Physician Phone #_____

Physician Fax # _____

I have reviewed the above information provided by my child's physician and am in agreement with his/or her instructions to the school nurse as they pertain to medicating my child in school.

_____ _____ - _____ - _____
Parent/Guardian Signature Parent/Guardian's Phone Number

_____
Date

Jack Schwartz, Ph.D
Executive Director

David Schwartz, MA
Director

Policy for Medication Administration on ½ Session Days of School

Date_____

Please be advised that all noon medications will be administered at 11:30 a.m. on ½ session days of school. Any medication that is ordered for 12:30 or later, **will not** be administered in school that day.

If your child will be receiving medication from the nurse, please sign below indicating that you have read and understand this policy for ½ session days of school. If your child's medicine is to be held on ½ days, then you must indicate so in writing a separate note to the school nurse.

I understand that my child, _____, will be receiving his or her noon medication at 11:30 a.m. on ½ session days of school and I have informed my child's doctor of this alteration to my child's medication schedule.

_____
Parent/Guardian

Jack Schwartz, Ph.D
Executive Director

David Schwartz, MA
Director

TO BE COMPLETED BY DENTIST/PHYSICIAN

Child's Name: _____

Date of Birth: _____

Sex: Male or Female

Date of Last Dental Exam: _____ Due Next_____

Teeth: _____

Gums:_____

Recommendations: _____

_____

_____

_____

_____

Dentist Signature_____