HIGH BRIDGE SCHOOL DISTRICT HEALTH SERVICES UPDATE *2019-2020*

High Bridge Elementary School 908-638-4105 908-638-5260 fax

High Bridge Middle School 908-638-4101 908-638-4211 fax

Student Name_____ Grade_____Homeroom_____Date of Birth_____
Parent 1/Guard._____ _____ _____ _____
Home phone Cell phone Work phone
Address_____
Parent 2/Guard._____ _____ _____ _____
Home phone Cell phone Work phone
Address (___Same as above) or _____

Student Health History & Medical Needs

1. Allergies and Emergency Medicine

Known Allergies: ___NO ___YES If yes: Seasonal____ (list below) Latex____ Perfumes/Chemicals_____
Allergies to Foods: _____ Allergies to Medications_____
Allergies to Bees/Insects/Dogs/Animals_____
Additional Information about Allergies_____

Emergency medications: ____Epi Pen ___Benadryl (diphenhydramine) *Must submit a doctor's order for each medication, available on the district website under the Nurse Tab and Virtual Backpack.*
___Asthma Rescue Inhaler *Middle school students are encouraged to have self-administration permission.*
___In previous years, my child had an order for ___Inhaler ___Epi Pen ____I am NOT continuing the order and I will submit a doctor's note to discontinue the medication need at school by 9/1/19.

___Other medication_____ *Must submit doctor's order for each medication.*

2. Ears and Eyes

Ear tubes? ___NO ___YES If Yes: Date Inserted: _____ ___Right ___Left
Date of last vision exam (not screening) _____ *Please submit vision report if possible.*
Corrective lenses? ___No ___Yes ____Eyeglasses ___Contact Lenses ___Soft ___Hard
Why? _____ When to wear? _____
Students may (and should) carry and store contact lens solution, carrying cases, rewetting drops for contacts.
Please consider having your child wear sports goggles for PE and Sports Teams.

3. Health Problems, Illnesses, Accidents

Significant illnesses (strep, chicken pox, etc.) and approximate date(s):_____
Serious injury/surgery/hospitalization and approximate date(s):_____
Current health problems? _____
Other conditions/special circumstances (e.g. migraines, seizures, low blood sugar, etc.)?_____
_____
Any physical limitations? (Doctor's note is required)_____

4. Medication taken regularly:

Medication	Dosage	Reason

Will this medication be needed during school hours? No _____Yes_____ *If yes, a doctor's order should be submitted along with the medication directly to the School Nurse on the first day of school.*

The Health Information contained herein **__ may __ may NOT** be shared with appropriate school personnel, as needed.
Parent/Guardian Signature_____ Date_____

High Bridge School District Health Services Update Authorizations Page

1. Medication Authorization

Our School Medical Inspector, Ronald M. Frank, M.D. has authorized the administration of the following medications by the School Nurse in the School Health Office, with parent/guardian written permission. If you would like your child to be able to receive any of the listed medication in school if needed, please complete the following and return it to the Health Office. Students will receive only ONE DOSE during the day. Telephone verbal permission from a parent/guardian will be requested prior to the administration of medication.

If two doses are needed in one month, a doctor's order will be requested.

PARENT/GUARDIAN PLEASE COMPLETE:
Student's name _____ Grade _____

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 NJAC: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)
___**A**cetaminophen, dosed according to weight and product label
___**I**buprofen, dosed according to weight and product label
___**T**ums/calcium carbonate, according to product label

Parent/guardian Signature _____ Date _____

_____ _____
Phone contact, cell or home Phone contact, 2nd

2. Scoliosis Authorization (Grades 5 and 7 only)

For those students in grades 5 and 7 with no sports physical on hand, the nurse performs stated-mandated scoliosis screenings during the year. Please indicate your desire for a scoliosis screening or not.

___Yes the school nurse may perform a scoliosis screening for my child. ___I wish to be present.

___No, please do not screen my child for scoliosis.

___My child is in treatment for scoliosis and is monitored by our physician or specialist. No screening at school is necessary.

3. GRADE 5 ONLY: FAMILY LIFE CLASSES PERMISSION

Health class in 5th grade is taught by the classroom teachers, the LEAD officer and Mrs. Gresko. The nurse teaches the family life portion of health and it may be intermittent throughout the school year. Please indicate your permission for the family life curriculum according to the High Bridge Board of Education Health Curriculum. Any questions can be directed to Mrs. Gresko when school begins.

I __ **do** give my child permission to take part in family life classes.
I __ **do not** give my permission for my child to take part in family life classes. I understand that a packet will be sent home to complete at home to fulfill this portion of the curriculum.

Parent/guardian Signature _____ Date _____