TOWNSHIP OF UNION PUBLIC SCHOOLS

NEW STUDENT REGISTRATION PACKET

If you are registering a new student to a Township of Union Public School, you must have the following:

1. Proof of required immunizations in the form of a school record, or a public health record. The record must be legible and translated into English by a doctor familiar with the immunization requirements.

2. Please ask the school nurse for information regarding free immunizations for students who do not have health insurance. Or go to:

   www.njfamilycare.og

   www.findahealthcenter.hrsa.gov

3. All students who are registering, regardless of where they are coming from, must have a physical examination within the past year. A physical examination form is enclosed in this packet for registration.

4. If the student is from another country, he/she may need proof of a Mantoux test done within the past six months.

TOWNSHIP OF UNION PUBLIC SCHOOLS
PROCEDURES REGARDING ADMINISTRATION OF MEDICATION IN SCHOOL

The administration of prescribed medication to a student during school hours will be permitted only when failure to take such medicine would jeopardize the health of the student, and the student would not be able to attend school if the medicine were not made available during school hours.

1. The school does not provide medication to students.
2. The parent/guardian or parent designee must bring in all medication.
3. The parent/guardian must provide a written request for the administration of the prescribed medication in school. (Signed Medication Authorization Form.)
4. *Non-prescription medication*: Written orders are to be provided to the school by the Primary Physician, detailing the name of the student, name of the drug, dosage, and time of administration. All non-prescription medication must be brought to school in the original container. (Signed Medication Authorization Form.) It is recommended that medications be given between 11:30 a.m. and 12:30 p.m., in order to maintain the continuity of the student's learning process.
5. *Prescription medication*: Written orders are to be provided to the school by the Primary Physician, detailing the name of student, name of the drug, diagnosis and the reason for administration of the drug, dosage, and time of administration. Must be brought to school in the original container with a ***current date***, appropriately labeled by the pharmacy or physician indicating the student's name, name of medication, diagnosis and reason for administration of the medication, dosage time of administration. (Signed Medication Authorization Form.) It is recommended that medications be given between 11:30 a.m. and 12:30 p.m., in order to maintain continuity of the student's learning process.
6. The school will provide safe storage of the medication.
7. The records or documentation process is required to be maintained by the certified school nurse.
8. The certified school nurse or parent/guardian is the only one permitted to administer medication in the school or on school trips.

CONSIDERATION FOR FIELD TRIPS

Children who require daily medication will need special consideration when planning school trips. The following is a list of appropriate options. Of course, each of these would require approval of the child's parent/guardian and physician. They include:

A. Altering the scheduled hours of administering the medication so the child is getting the first dose at school (about 9:00 a.m.) and the second dose after the class returns (usually about 2:00 p.m.).
B. Withholding medication during the course of that particular activity and giving it when the student returns to school.
C. Requesting that a parent/guardian of the affected child accompany the group to administer the medication to the child.

Linda Ionta, Director
Health and Medical Services

Revised 6/11/04
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Linda M. Ionta, Director
Athletics, Health, Physical Education & Nurses

REQUEST FOR HEALTH RECORDS

Date ____________________

Student's Name: ____

Date of Birth: ________________________ Grade: __________

Name of previous school: ________________________________

Address of previous school: ______________________________

City: ____________________ State: ________ Zip Code: ________

Please send the original A-45 and other pertinent health information to:

☐ Burnet Middle School
Health Office
1000 Caldwell Avenue
Union, NJ 07083
#908-851-6498

☐ Kawameeh Middle School
Health Office
490 David Terrace
Union, NJ 07083
#908-851-6579

☐ Union High School
Health Office
2350 N. Third Street
Union, NJ 07083
#908-851-6550

☐ Battle Hill Elementary
Health Office
2600 Killian Place
Union, NJ 07083
#908-851-6488

☐ Connecticut Farms Elementary
Health Office
875 Stuyvesant Avenue
Union, NJ 07083
#908-851-6477

☐ Franklin Elementary
Health Office
1550 Lindy Terrace
Union, NJ 07083
#908-851-6455

☐ Hannah Caldwell Elementary
Health Office
1120 Commerce Avenue
Union, NJ 07083
#908-206-6104

☐ Jefferson Elementary
Health Office
155 Hilton Avenue
Vauxhall, NJ 07088
#908-851-6566

☐ Livingston Elementary
Health Office
960 Midland Blvd.
Union, NJ 07083
#908-851-6444

☐ Washington Elementary
Health Office
301Washington Avenue
Union, NJ 07083
#908-851-6466

Please send to appropriate school. Thank you for your anticipated cooperation!

UNION TOWNSHIP PUBLIC SCHOOLS
UNION, NEW JERSEY 07083

STUDENT HEALTH HISTORY

Student's Name: ______________________________

Date of Birth: ______________________________

Birthplace: ______________________________

Where did the student reside before entering this school?

______________________________ **(City/State)**

______________________________ **(Country)**

	YES	NO
Is this the first time this student will attend school in the United States?	____	____
Has anyone in student's close family ever had		
Diabetes (high sugar in blood)?	____	____
Allergies (hay fever or asthma)?	____	____
Migraine headaches?	____	____
Heart trouble?	____	____
High blood pressure?	____	____
Sudden death?	____	____
Has student had or does student have		
Tendency to lose consciousness (faint)?	____	____
Convulsions or epilepsy?	____	____
Heart trouble?	____	____
High blood pressure?	____	____
Persistent cough?	____	____
Chest pain with exercise?	____	____
Dizziness or faintness with exercise?	____	____
Has student had or does student have		
Very bad (impaired) vision in one eye?	____	____
Temporary loss of vision?	____	____
To wear glasses or contact lenses?	____	____

	YES	NO
Has student had or does student have		
Hearing loss?	____	____
Perforated ear drum?	____	____
Sinus infection?	____	____
Broken nose?	____	____
Orthodontia (teeth straightened)?	____	____
Has student had or does student have		
Kidney problems?	____	____
(Boys) Loss of function or absence of testicles?	____	____
(Girls) Menstrual problems?	____	____
Age of onset of menstruation_______________		
Has student had or does student have		
Asthma (wheezing)?	____	____
Hay fever?	____	____
Hives or rash?	____	____
Bee sting reactions (allergy)?	____	____
Reaction to medicine (allergy)?	____	____
Has student or does student		
Smoke?		
Take any medicine regularly?	____	____
If yes, name_________________________		
Take medicine for emergency use?	____	____
If yes, name_________________________		
Has student or does student have any injury?	____	____
Has student had or does student have		
Tendency to bleed or bruise easily?	____	____
Anemia ("tired" blood)?	____	____
Weight problem (under or overweight)?	____	____
Has student had or does student have a skin condition?	____	____
If yes, name_______________________________		
Has student ever been told to give up sports because of health problems?	____	____

Additional information concerning "YES" checked above: ________________________

____

____

Parent/Guardian's Signature   Date

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

Condition		Comments
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	

 Distribution: Original-Child Care Provider Copy-Parent/Guardian Copy-Health Care Provider

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.

Township of Union Public Schools

Linda M. Ionta, Director
Athletics, Health/Physical Education/Nurses

Dear Parent/Guardian:

New Jersey State Legislature mandates that students between the ages of 10 and 18 (Grades 5, 7, 9 and 11) shall receive a school examination every other year for scoliosis (a curvature of the spine).

The purpose of this program is to recognize the problem at its earliest stages so that the need for treatment can be determined.

If further consultation is recommended, parents/guardians of students who are found to have signs of a possible spinal abnormality will be notified and will be asked to see their own physician for further evaluation.

If your child is currently under active treatment for a spinal problem or you would rather not have your child screened, please return the bottom portion of this letter to the Nurse's Office.

This ***will be the only notification*** you will receive while your child is in the Township of Union Public Schools.

Sincerely,

Linda Ionta, Director
Athletics, Health, Physical Education & Nurses

PLEASE RETURN WITHIN ONE WEEK TO THE SCHOOL NURSE

Child's Name ______________________ Grade ________ Homeroom ________

☐ I do not wish my child screened for spinal curvature.

☐ My child is currently under care for a spinal problem with Dr.______________________.

☐ I wish my child screened for spinal curvature.

Parent/Guardian Signature ______________________ Date ________

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