MONTGOMERY TOWNSHIP SCHOOL
Skillman, New Jersey

SCHOOL HEALTH SERVICES

PRE-K-4

To: Parent/Guardian
Re: Transfer Student

Pursuant to State Law, N.J.A.C. 6A:16-2.4 (d), all students transferring into a New Jersey Public School, are required to provide an entry physical examination.

If you do not have a report of your child's exam at the time of registration, or your child has not yet had this examination, please check one of the following statements.

____I will have my child examined by a private physician at my expense and within 30 days will submit a report of this examination by the physician.

___ My child has received a physical within the last 365 days. I will submit a report of this examination within 30 days.

____________ ____________________________________
Date Student's Name (please print)

____________ ____________________________________
Date Parent/Guardian Signature

NOTE:

POSSIBLE SCREENING TEST FOR TUBERCULOSOIS MAY BE REQUIRED FOR YOUR CHILD IF ATTENDING SCHOOL FOR THE FIRT TIME IN THE UNITED STATES OR TRANSFERRING INTO THE NEW JERSEY SCHOOL SYSTEM DIRECTLY FROM A COUNTY THAT IS NOT IDENTIFIED AS A LOW INCIDENCE COUNTY OF TUBERCULOSIS. <u>Please contact the nurse of the school your child will be attending for verification weather or not this tuberculosis screening is required.</u> This mandate is required by the rules of the State Board of Education and the New Jersey Department of Health (N.J. Regulation 6:29-4.2 and state law N.J.S. A. 18A:40-16.)

UNIVERSAL
CHILD HEALTH RECORD

Endorsed by: *American Academy of Pediatrics, New Jersey Chapter*
New Jersey Academy of Family Physicians
New Jersey Department of Health and Senior Services

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	

CH-14 SEP 08 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 and Senior Services, Immunization Program at 609-588-7512.
   - 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.state.nj.us/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.

FORM C: School Health Services Form

MONTGOMERY TOWNSHIP SCHOOLS
Skillman, New Jersey

SCHOOL HEALTH SERVICES

Student's Name: ______________________________ Date of Birth: ____________
(Please print)

Gender: Male / Female (circle one)

My child previously attended a Montgomery Twp. School Yes / No (circle one)

If yes, circle last school attended OHES VES LMS UMS MHS

HEALTH HISTORY

Has Your Child Had:	NO	YES	YEAR
Chicken Pox			
Heart Problems			
Kidney Problems			
Bladder Problems			
Asthma			
Bronchitis			
Strep Infection			
Mononucleosis			
Diabetes			
Convulsions			
Hepatitis			
Rheumatic Fever			
Pneumonia			

Does Your Child Have:	YES/TYPE	NO
Congenital Defects		
Drug Sensitivities		
Neuromuscular Disease		
Speech Problems		
Vision Problems		
Eyeglasses		
Hearing Problems		

Has your child had:	If yes, description and date.
Any severe injury?	
Any operations?	

Initial the statement that applies to your child:

______My child does **not** have a life-threatening allergy requiring the use of epinephrine.

______My child has a life-threatening allergy requiring the use of epinephrine. **Please complete the Life-Threatening Allergy Questionnaire on the following page.***

Parent/Guardian Signature:______________________________________Date:________________

Revised 3/22/2016

PLEASE COMPLETE THE NEXT THREE FORMS ONLY IF YOUR CHILD HAS ANY LIFE-THREATENING ALLERGIES.

Montgomery Township Schools

Life-Threatening Allergy/ Asthma Questionnaire*

Grades Preschool - 4

***This form should be completed ONLY if your child has a Life-threatening Allergy**

Student's Name: ______________________________ For School Year: __________

Date of Birth: __________ My Child will be in the following grade during the School Year listed above: __________

1. List all known life-threatening allergens (food and non-food):

____

2. Has your child ever received a shot of epinephrine for an episode of anaphylaxis to any of the allergens listed above?

   ☐Yes ☐No

   2a. f yes, briefly describe symptoms: ______________________________

3. Does your child have a prescribed epinephrine auto-injector? ☐Yes* ☐No
   ***A health care provider completed Montgomery Township School District Allergy Action Plan is required if your child has a life-threatening allergy indicating the use of epinephrine in school. The MTSD Allergy Action Plan and other forms can be obtained through your child's school nurse. This form must be renewed every school year.**

4. Will your child carry an epinephrine auto-injector in their backpack during school? ☐Yes* ☐No
   ***Written authorization for your child to carry an epinephrine auto-injector is required from a health care provider- refer to top section on back page of MTSD Allergy Action Plan.**

5. Regarding lunch (complete questions 5 & 6 only if entering grades 1-4, not applicable for students entering Pre-K and K):

   ☐ My child may purchase school-prepared lunch-
   School and cafeteria staff will not make any determination of food safety as related to life-threatening allergens. Parents should review the Chartwell menu in advance of student's purchase. Please refer to the OHES or VES websites under 'Lunch Menu" selection for more information.

   ☐ My child is not allowed to purchase school-prepared lunch-
   Parent will provide daily lunch from home

6. During lunch, my child must sit at: (check only one)

   ☐ No seating restriction required

   ☐ Peanut-free table* ☐ Liquid dairy-free table* ☐ Peanut & liquid dairy-free table*

   ***Only students with a completed Allergy Action Plan for the current school year are allowed to sit at the peanut & liquid dairy-free tables. There will be no exceptions made. The lunchroom aides will have a list of students with life-threatening allergies and will be monitoring the tables for compliance.**

7. Does your child have asthma? ☐Yes ☐No 7a. Will you provide an inhaler to keep at school? ☐Yes* ☐No
   *** As per: N.J.S.A. 18A:40-12.8, a health care provider completed NJ Asthma Treatment Plan is required if your child uses an inhaler during school, even if they are not diagnosed with asthma. See school nurse for this form.**

Parent/Guardian Signature: ______________________________ **Date:** __________

The following to be completed by School Nurse:

1. Epinephrine provided: ☐Yes ☐No **2. AAP provided:** ☐Yes ☐No **3. IHP completed:** ☐Yes ☐No

4. IHP signed by parent: ☐Yes ☐No **5. Transportation notified:** ☐Yes ☐No **6. Genesis updated:** ☐Yes ☐No

Notes:

____

____

Revised 3/22/2016

Montgomery Township School District

Emergency Allergy Action Plan

School Year: ____________________

Affix Student's Picture Here

Student's Name: ______________________________ DOB: ____/____/____

Teacher: ______________________ Home Room: ____________ Grade: ________

Physician/Health Care Provider to complete & sign:

List all known life-threatening allergens: ______________________________

Asthma: ☐ **- Yes (increased risk of severe reaction)** ☐ **- No**

The following statements apply ONLY to food allergens:
Extremely Reactive to the following food(s): ______________________________
Therefore:

☐ If checked, give epinephrine immediately for any symptoms if the allergen was likely eaten.

☐ If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

SEVERE SYMPTOMS after suspected or known ingestion or exposure to allergen:

One or more of the following:

- LUNG: Short of breath, wheeze, repetitive cough
- HEART: Pale, Blue, Faint, weak pulse, dizzy, confused
- THROAT: Tight, hoarse, trouble swallowing or breathing
- MOUTH: Obstructive swelling (tongue and /or lips)
- SKIN: Many hives over body

Or combination of symptoms from different body areas:

- SKIN: Hives, itch rashes, swelling (e.g., eyes, lips)
- GUT: Vomiting, diarrhea, crampy pain

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911 – Request Ambulance with epinephrine
3. Continually monitor student's condition
4. Administer antihistamines & inhaler/ bronchodilator† if asthma (only RNs may administer)*

*Delegates are not authorized to administer antihistamines or bronchodilators per statute- N.J.S.A. 18A:40-12.6.

†Antihistamines & Inhaler-bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). **USE EPINEPHRINE!**

Medications/Dosage:

Epinephrine (auto-injector dose): ______________________________

Administer a second dose of epinephrine if student's condition does not improve within 10-15 minutes after the first dose is given: YES/NO

Antihistamine (dose): ______________________________ (*Delegate cannot administer

Other (e.g., inhaler-bronchodilator if asthmatic): ______________________________ (*Delegate cannot administer)

MILD SYMPTOMS ONLY:

- MOUTH: Itchy mouth/throat
- SKIN: A few hives around mouth/face, mild itch
- GUT: Mild nausea/stomach ache

1. **GIVE ANTIHISTAMINE***
2. Monitor student's condition
3. If symptoms progress (see above). **USE EPINEPHRINE!**

Antihistamine (dose): ______________________________ (*Delegate cannot administer)

TURN FORM OVER

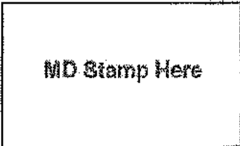
Capacity for self-administration of epinephrine
Physician/Healthcare Provider should initial applicable statement:

_____ Student **must carry** his/her epinephrine during the school day and is **capable of self-administration**. He/she has received instruction, and demonstrates the proper use of epinephrine using a training device. **If for any reason the student cannot self-administer, the nurse, or delegate will administer the epinephrine.** I understand that a delegate cannot administer antihistamines.

_____ Student **does not have the capacity for self-administration** of epinephrine, but will **carry** this medication to be administered by a nurse or delegate in the event of an emergency. Transportation services will be notified. I understand that a delegate cannot administer antihistamines.

_____ Student **does not have the capacity** for self-administration of epinephrine. An auto-injector of epinephrine will be provided to the nurse's office at the beginning of each school year and a nurse or delegate will administer this medication as needed.

X____ / ______________
Physician/Healthcare Provider Signature *Date*



Emergency Contact Information:
Please PRINT LEGIBLY contact names and phone numbers in order of priority

1. Parent/Guardian Name (PRINT)	*Preferred Phone*	*Alternate phone number*
2. Parent/Guardian Name (PRINT)	*Preferred Phone*	*Alternate phone number*
3. Parent/Guardian Name (PRINT)	*Preferred Phone*	*Alternate phone number*

PLEASE NOTE: For students with diagnosed life-threatening allergies, the following bulleted items must be provided & updated each school year for emergencies during school and off-campus events (e.g. field trip, overnight trip, sports.)

- All emergency medications as noted by the student's physician with current expiration date
- If a 2nd dose of epinephrine is authorized by Health Care Provider (see front of form), please provide two auto-injectors.

Please be advised that your child will not be allowed to participate in athletics, field trips, overnight trips or school sponsored events without a completed and current MTSD Allergy Action Plan on file in the health office.

I understand that in the event of an anaphylactic emergency, epinephrine will be administered to my child by a school nurse and/or delegate as indicated in this allergy action plan. My signature below indicates my acknowledgement that the school district and its employees or agents shall have no liability as a result of any injury arising from the administration of epinephrine to my child. I shall indemnify and hold harmless the district and its employees or agents against any claims arising out of the administration of epinephrine via a pre-filled auto injector mechanism.

Parent/Guardian Signature: X_______________________________________ *Date:*______________

School Nurse Signature: X_______________________________________ / *Date:*______________

Revised 06/08/15