2023 / 2024 School Year

Dear Parent (s) / Legal Guardian:

Warren Glen Academy requires a parent/guardian of a student who is absent to notify the school of the absence. Please notify the school nurse who will document the absence. If I do not receive a phone call, I will call the parent/ guardian to inquire about the absence. When you call school regarding an absence, or any health issue, you may leave a message on my secured extension, 109. Please include your name, the student's name, the dates and reason for the absence. I will then be able to track any illness going around the school as well as documenting the student's illness in his record. You may leave a message on my voice mail at any time. You do not have to wait until school is in session or wait for the greeting to be completed. When you call the school, after the recording begins, press #3 or extension 109 to reach the Health Office. All messages are confidential; I will be glad to notify the teacher of the student's absence. If you know in advance that your child will be absent for an appointment etc. you may call ahead to inform me; I will make a note on my calendar, and you will not need to call the day of an appointment.

If your child is seen by a physician, please ask for an excuse for school. The note will be placed in your child's medical file. Often school districts ask to see a students attendance record. If I have a physician note available, I will make the school district aware. Please remember if a student is absent for three consecutive days, a physician's note is required to return to school.

A FEW REMINDERS:

Please keep me updated regarding any medication changes made throughout the year, even if the medication is not administered in school. This allows me to better assess a student coming to the health office with symptoms attributed to side effects of medication. It also provides us with the current information should an emergency arise and that your child is sent to a hospital. Although you will be notified immediately of your child's need to be hospitalized, the information will be helpful for emergency personnel to begin an immediate evaluation.

***** It is extremely important to contact the school with any change in address or phone number. If you have a cell phone available, please notify us of that number and try to include an emergency contact person who is available during the day at a number you provide for them.

Many students have been prescribed medication. With this in mind, we would like a copy of the students' latest physical. It is required by State law that each student have a physical annually from grades K thru 3rd; once in grade 4 thru 6 and once in grade 7 thru 12. WGA accepts the Universal physical form which is included in your packet. We follow New Jersey State guidelines regarding Immunization requirements. These are required upon entrance to our school with an update when a student is on the 6th grade level.

Thank you for your cooperation. If you have any questions or concerns now or throughout the school year, please feel free to contact me at 908-995-1999#3. If I am with a student, please leave a message. I will return your call.

Best Regards,
The School Nurse

Dear Parent/Guardian of students who receive routine medication in school:

Please note that ALL medications are to be brought to the school in the original medication container dispensed by the pharmacy. State regulations require that all medications be dispensed from a pharmacy bottle. The correct dose must be printed on the label.

In order, for the medication to be administered at school, the nurse must also have a written doctors order. If the medication dose changes during the year, we must also have a current order for that change. Your child's physician may **fax** the order directly to Warren Glen Academy: **908-995-1994.** The medication must be brought to school by a parent/guardian or given to the bus driver, who in turn will deliver it to a staff member. The children are not allowed to carry/bring the medication to school. We regret any inconvenience this may cause you.

When your child has a few days' supply left at school, I will call or send a note home requesting a new supply. If you need the labeled bottle, please let me know. When returning a medication supply, please notify me of the quantity of pills dispensed if it differs from the existing pharmacy label.

Any questions or concerns please contact me at school, 908-995-1999, extension 109.

Thank you,

School Nurse

Dear Parent/Guardian:

Attached please find the medication forms that you may need for your child. For medication to be administered in the school setting, a physician order in addition to parental permission needs to be on file. Please review the attached forms and contact me if you have any questions or concerns. I can be reached at 908-995-1999 ex 109. The following is a brief explanation of the attached forms.

1. **PRN medication form-** If you would like your child to be given Acetaminophen (Tylenol), Ibuprofen (Motrin, Advil), Benadryl, or Tums as needed, please complete this form. Our school physician has given a standing order for these medications; however, I also need parental consent to administer these medications.

2. **Medication/Doctor's Order to dispense form-** This form is to be used for any **routine medication** order (medication that is administered each day) or **any other PRN** (as needed) medications besides the medications listed on our standing order form. The physician completes the top half and the parent completes the bottom portion. Both sections need to be completed in order to administer the medication in school.

3. If your child has asthma and uses an inhaler, please have their physician complete the **Asthma Action Plan** form. As the parent, please be sure to also sign the form which gives consent for the use of the inhaler.

4. The form known as the **Permission for Self-Administration of Medication** form is required if you would like your child to be able to carry their epi-pen or inhaler. This is extremely useful especially during a field trip when students are in various groups throughout the area. Inhalers and epi-pens are held in the health office while in school usually kept by the school nurse who accompanies the students on a field trip.

5. The **Allergy Form: If your child has the type of allergy which may require treatment (example, antihistamine or epi-pen) an allergy form must be completed by his/her doctor.**

6. ****Please note that if your child required more than one medication to be administered in school, a separate medication form must be completed for each medication. If you need additional copies, please feel free to call the school.

7. If you have any questions regarding these forms, please feel free to contact me. You may leave a voicemail message with a return phone number for me to contact you. (My voicemail is confidential, my substitute being the only other person having access). During the summer months, my hours may vary. I will return your call as soon as possible. If, the issue is urgent, you may leave a message with a substitute nurse or the school secretary.

Warren Glen Academy

PRN MEDICATIONS

Our School Physician has written standing orders allowing the School Nurse to administer Acetaminophen (Tylenol) or Ibuprofen (Advil/Motrin) for fever or pain, Benadryl for allergic reaction and Tum (s) for GI discomfort, provided written permission is granted by the parent/guardian.

Please indicate your permission below, by signing for **EACH** medication separately that you are giving permission to administer as needed.

Student Name ______________________________________ Date of Birth ____________

Allergies: ____

The School Nurse **has my permission to administer the following:**

Acetaminophen (Tylenol) **Parent/Guardian signature** ______________________________

Ibuprofen (Advil/Motrin) **Parent/Guardian signature** ______________________________

Benadryl **Parent/Guardian signature** ______________________________

Tum **Parent/Guardian signature** ______________________________

Parent/Guardian PRINT name ____________________________________ **Date** __________

***Please note, if your child will need any other medication beside the four medications listed above, you will need to obtain a Physician's order from your child's physician. Please request medication forms from the School Nurse if you do not already have one. Medication orders are only good for one school year and need to be renewed yearly.

Warren Glen Academy

PERMISSION FOR SELF-ADMINISTRATION OF MEDICATION*

*To be accompanied by "Medication/Doctor's Order to Dispense" **or**"
"Order for Pre-filled, Single Dose Autoinjector Mechanism containing Epinephrine"

A pupil may be permitted to self-administer medication for asthma, allergic reactions to insect stings or other potentially life-threatening illness. The parent/guardian must present written authorization for the self-administration of the medication. (The student must be observed by a staff member)

The child's physician must certify in writing that the child has asthma, or another life-threatening illness and that the child is capable of and has been instructed in the administration of the prescribed medication.

The parents/guardians must sign a statement acknowledging that Warren Glen Academy employees or agents shall incur no liability as a result of any injury arising from the self-administration of medication by the pupil, and that the parents/guardians shall indemnify and hold harmless the school and its employees or agents against any claims arising out of the self-administration of this medication by the pupil.

This permission must be renewed annually.
Your child's medication will be kept in the Health Office and will be provided as needed per M.D. directive. Please complete the form with the physician and return it to the school nurse.

I request that my child ______________________________, be allowed to carry with him/herself the following medication: ______________________________. I realize that Warren Glen Academy, its employees, or agents, shall incur no liability as a result of any condition or injury arising out of the self-administration of medication.

____ Date ________________
(Parent/Guardian signature)

Physician, please complete the following:

I certify that ___________________________________ has the following life-threatening condition _________________________________ and that he/she is capable of and has been instructed in the proper self-administration of the following medication:

____

______________________________________ ______________________________________
(Printed Name of Physician) (Physician's Signature)

______________________________________ ____________________ ________
(Address) (Phone) (Date)

Signature of School Director ______________________________ Date _________

Student Health Questionnaire

It is very important that your child's school health records remain up to date. Please fill out this form with health information that would benefit the nurse or teacher in caring for your child.

Students Name: ____

_______ My child does not have any significant health problems at this time.

****List all current Diagnosis** ____

____

Please be aware of: (please give dates)

Recent surgery____

Serious injury or illness____

Allergies: (include all allergies) ____

Recent boosters____

****Please have physician's office send confirmation of booster(s) to the school. Attention: school nurse

Vision corrections: Wears glasses__________ Wears contacts__________ None_________

Hearing problems________ Seizures_______ Asthma________ Heart disease____________

Hepatitis________ Diabetes__________

Is your child taking any medication at this time? Yes______ No__________

Please list ALL medications taken including AM and PM doses taken before and after school. List the name of medication, dosage and time taken.

For medications to be administered in school PLEASE ATTACH THE PHYSICIAN ORDER.

____

____

____

____

____

Physician's name & Phone number____

Psychiatrist's name & Phone number____

Parent/Guardian's Signature______________________________ **Date**______________

Warren Glen Academy

Allergy Action Plan (food or insect)

Student's Name: ______________________________ **D.O.B.**______________________

Allergy to: ____

Asthmatic: □ **YES*** □ **NO** ***Higher risk for severe reaction**

Step 1 Treatment

Symptoms: **Give checked medication**

If your child has any symptoms of an allergic reaction of any kind, Warren Glen Academy has standing orders from our school doctor to give Benadryl for a mild reaction, such as a rash or mild itching. For symptoms such as, severe hives/rash, swelling in the face and or tongue, nausea/vomiting/abdominal cramps, tightness in throat or trouble breathing, low blood pressure/fainting or pulse that is hard to feel, trained staff will administer an Epi-Pen appropriate for your child's age/weight.

The severity of symptoms can quickly change. *Potentially life-threatening. By law we are to have on hand, two different Epi-pens. Epi-pen Jr. is for children who are under 66lbs., and the other is for anyone over 66lbs.

Epinephrine: Inject intramuscularly per child's weight/per our school doctor's standing orders.
Antihistamine: Benadryl will be given per our school doctor's standing orders.

If you want a different antihistamine used, the school nurse will need a doctor's order and medication brought in by parent.

Other Antihistamine: ____

Medication/dose/route

Step 2: Emergency Calls to 911 and Parent/Guardian

1. **Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.**
2. Dr. ______________________ at ____
3. Emergency Contacts:

Name/relationship	Phone Numbers	
______________________	1) ________________	2) ________________
______________________	1) ________________	2) ________________
______________________	1) ________________	2) ________________

Even if Parent/Guardian cannot be reached, Do not hesitate to medicate or take child to Medical Facility

Parent/Guardian Signature ______________________________ **DATE**____________________

Doctor's Signature: ______________________________ **DATE**____________________

Warren Glen Academy

School year 2023-2024

Dear Parent(s):

Re: Scoliosis Screening

Scoliosis is a lateral curvature of the spine most commonly detected during the adolescent growth period. It is estimated that between 5% and 10% of school children have such a curvature to varying degrees. However, only about 2% of these curvatures are significant. If someone else in the family has scoliosis, the likelihood of incidence is much higher-approximately 20%. The effect of scoliosis depends upon its severity, how early it is detected, and how promptly it is treated.

Scoliosis screening is performed annually between the ages of 10 and 18. The goal of this mass screening program is early identification, because curvatures can often be controlled if detected early. Students diagnosed with scoliosis should be under the care and supervision of a family healthcare provider or clinic. Referral to an orthopedist or orthopedic clinic may also be indicated.

Kindly complete this form and return it to me. Scoliosis screening will be part of the yearly health screening.

Thank you,

School Nurse

____ I understand my child will be screened for scoliosis in the 2023/2024 school year.

____ My child is currently being followed by his/her physician for this screening or for treatment of this condition.

Physician name and phone number ____

_____ Please do not perform this screening on my child.

** Please note that if this form is not returned, your child will be screened for scoliosis.

Signature of parent ________________________________ Date ______________

PARENTAL CONSENT TO SHARE HEALTH INFORMATION

Dear Parents/Guardians:

The laws regarding confidentiality and health information have become increasingly stringent. In order to ensure that your child's health needs are adequately met in school, it is important to share information with the teachers who are directly involved with your child. Before this information may be shared, we must have your written consent. Written/verbal information regarding your child's condition, symptoms to watch for, and action to take if a problem arises will be provided to the teachers indicated. If you do not want information shared with anyone on this list, please INITIAL the line that indicates this, and sign and date the bottom of this page. If you would like information to be shared with school staff, INITIAL next to each member that you are giving permission. This consent will be effective for the school year of July 2021 to June 2022. You may waive this consent at any time by indicating this change in writing.

Student Name: ______________________________ Birth date: ________

List health concerns: ____

Initial which staff members are permitted to have medical information about your child (substitutes will be given information on an "As needed" basis if covering for a staff member that you have granted permission)

Initial which staff members are permitted to have medical information about your child (substitutes will be given information on an "As needed" basis if covering for a staff member that you have granted permission.

____ Level I teacher and classroom aide

____ Level II teacher and classroom aide

____ Level III teacher and classroom aide

____ Level IV teacher and classroom aide

____ Administration

____ Reflection Room Staff

____ Speech Teacher

____ Art Teacher

____ Tech Ed Teacher

____ Other (please indicate) ______________________________

I give my consent for the school nurse to provide the staff members indicated above written/verbal information regarding the management of health concerns for my child.

____ Initial if you do NOT want your child's information shared with any staff members.

Parent/Guardian signature: ______________________________ INITIALS________ Date: ________

**** You must INITIAL for this form to be valid. Check mark will not be accepted. ****

2023/2024 School Year

Dear Parent/Guardian:

As per Board Policy #5330, we are informing you of the following information pertaining to the administration of medication, specifically in the use of a pre-filled auto-injector mechanism (also known as an Epi-Pen).

Our School Nurse, as well as staff members have been trained in the use of an auto-injector. The school and its employees shall have no liability as a result of any injury to a student arising from the administration of epinephrine via a pre-filled auto-injector mechanism.

Sincerely,

Dr. Randy Pratt
Executive Director

____ I understand that the Warren Glen Academy shall incur no liability as a result of any injury arising from the administration of epinephrine via a pre-filled auto-injector mechanism to the student and the parent shall indemnify and hold harmless the school and its employees or agents against any claims arising out of the administration of epinephrine via a pre-filled auto-injector mechanism to the student.

______________________________ ______________________________
Print Name of Student Signature of Parent

____
Date

WARREN GLEN
ACADEMY

2023/2024 SCHOOL YEAR

Dear Parent/Guardian:

Please read, sign and return to school. Any questions or concerns please feel free to contact the school nurse.

RE: Protocol for any suspected illness or rash that may be contagious.

It is at the discretion of the school nurse and school policy to determine if an illness of rash may be contagious. If the school nurse using her medical knowledge feels that a condition may jeopardize the health of other students, she will contact the student's parent or guardian and request that they come to school to take the child home. Depending on the physician's diagnosis, a minimum period of 24 hours of treatment is needed before returning to school with longer periods of time needed for some conditions. The child must present a physician's note stating the date the child my return to school and the treatment prescribed.

Upon receiving this note, the child will be allowed to return to school. In certain circumstances, the child may be asked to keep the area covered while in school, such as a rash, to protect the other students.

Some common conditions that you may receive a call to come pick up your child are as follows but not limited to:

Chicken Pox (Varicella)
Conjunctivitis (Pink Eye)
Impetigo
Measles
Mumps
Fifth's disease (rash with fever)
Poisons (such as poison ivy, oak, sumac)
Ringworm
Rubella (German Measles)
Scabies
Staph or Strep Infections

Parent 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 <u>that is being used to complete the form</u>. 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 <u>should</u> 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.

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	