The Queen City Academy Charter School
815 West Seventh Street
Plainfield, New Jersey 07063
Phone 908.753.4700 Fax 908.753.4816
www.queencity.edu

Accredited by the Middle States Commissions on Elementary and Secondary Schools

Danielle M. West
Chief Academic Officer/Director

Dr. Carl Bampoe
Assistant Academic Director

Health Assessments/Physical Examination Requirements

Dear Parents/Guardians:

Please be advised that the Health Assessment Packet must be completed for all students entering The Queen City Academy Charter School in September 2018. The completion and prompt return of this packet is mandatory. This packet consists of the Student Health History, Emergency Information Form, the Consent for Screenings and Health Treatment Forms. In the back of the packet is the Medical Form along with the Medication Forms. **A yearly physical is mandatory for all students. Detach the medical section and return the rest of the packet immediately**. **The Medication Policy and Authorization Forms are included if your child requires medication to be given during school hours.**

In order to ensure that the learning potential of each student is not diminished by a remediable physical disability, that the student is able to participate in the school program, and the school community is protected from the spread of communicable diseases, certain physical examinations are required.

Each student's medical examination must be conducted by a healthcare provider or advanced practice practioner chosen by the student's parent/guardian. A full report of the medical examination documented on the approved school district form, dated, signed and stamped by the medical provider-must be presented to the school. If a student does not have a "medical home or medical provider," the district may provide the examination at the school physician's office or other appropriately equipped facility. (N.J. Department of Education, Office of Educational Support Services-conducting health assessments, 10/2001)

ALL STUDENTS MUST HAVE A DOCUMENTED ANNUAL PHYSICAL ON FILE IN ORDER TO FULLY PARTICIPATE IN ALL PHYSICAL ACTIVITES.

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STUDENT HEALTH HISTORY

NAME_____ **DATE OF BIRTH**_____ **SEX**_____
LAST & FIRST MM-DD-YYYY M/F

STREET_____ **EMAIL** _____

CITY, STATE & ZIP _____

HOME_____ **WORK**_____ **GRADE**_____
INCLUDE AREA CODE INCLUDE AREA CODE

PARENT/GUARDIAN NAME_____

MEDICAL HISTORY – To be completed by parent or guardian. Please provide the information below. If none applies, check the N/A box. **ACCORDING TO HIPPA REGULATIONS, ALL INFORMATION REPORTED WILL REMAIN CONFIDENTIAL**.

MEDICAL INFORMATION	**MORE INFORMATION**
ALLERGIES: Allergic reactions (hives, rash, difficulty breathing) from food, medications, animals, insect bites, pollen, etc.	{ } N/A
BIRTH OR ACQUIRED ABNORMALITIES: Deformities, defects, single paired organs(one eye, kidney, testicle, etc.) speech, hearing impediment, etc.	{ } N/A
COMMON CHILDHOOD DISEASES: Chicken Pox, Measles, Mumps, Whooping Cough, (Month & Year).	{ } N/A
CHRONIC DISORDERS: Diseases of the heart, lungs, digestive systems, nervous system, urinary tract, spleen, glands, etc.	{ } N/A
HEALTH AIDS: List for glasses, contact lens, Hearing aids, braces/retainers, splints, etc.	{ } N/A
INJURIES: Fractures, dislocations, loss of limb, head injuries, concussions, frostbite, disfigures.	{ } N/A
MEDICATION: List all prescriptions meds taken regularly, i.e. inhalers, insulin, nebulizer, injections	{ } N/A
SPECIFIC DISORDERS: History of ADHD, asthma, sickle-cell disease, hernia, enlarged spleen, convulsions, disorders of the spine, high b/p	{ } N/A
SURGICAL PROCEDURES: List names, dates of hospitalization	{ } N/A
Do you have Medical Insurance? Yes /No	Name of Pediatrician

SIGNATURE OF PARENT/GUARDIAN_____

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July 16, 2018

To: Parents/Guardians

From: Danielle West, Chief Academic Officer/Director
Judith Hester, RN MA CSN

Re: Nursing Serves Chapter 226- Law of 1991, New Jersey legislation provides nursing services for students in school.

Included in these services are:

- Blood pressure screening age 5 and above
- Dental screening K-8
- Health screening of height and weight
- Hearing screening grades K-4, 6, and 8
- Vision screening grades K-8
- Scoliosis screening
- Maintenance of health and immunization records

In addition, students who are injured or become ill during school hours will be provided with the appropriate emergency care. Please complete this permission form and return it by September 5, 2018. Screenings will begin in December 2018 with grades K-5, and continue with grades 6-8 in January 2019.

_____**I do** give permission for my child (ren)
to participate in these services. Name_____ grade_____
_____ grade_____
_____ grade_____
_____ grade_____

_____**I do not** give permission for my child (ren)
to participate in these services. Name_____ grade_____
_____ grade_____
_____ grade_____
_____ grade_____

Signature of Parent/Guardian _____

Date _____

The Queen City Academy Charter School

EMERGENCY INFORMATION FORM

My son/daughter, _____ has my permission to participate in the physical education program of The Queen City Academy Charter School. While I expect the school authorities to exercise reasonable precaution to avoid injury, I understand that they assume no financial or moral obligation for any injury that may occur.

Signature of Parent or Guardian _____ Date _____

Mother's Name and Address _____

Home Number _____Email_____ Cell #_____

Father's Name and Address _____

Home Number _____ Cell #_____

Student's Doctor _____ Doctor's Number_____

IN CASE OF EMERGENCY, ILLNESS, OR ACCIDENT: PLEASE TYPE OR PRINT

Mother's Job Name and Address _____

Business # _____

Father's Job Name and Address _____

Business # _____

Name , address, and telephone number of a responsible adult if either parent cannot be contacted:

_____

Name Address Telephone number

_____

Name Address Telephone number

Permission to administer first aid treatment until a parent or family doctor can be contacted.
Yes _____ No _____

Permission for School authorities to use their own judgment in securing medical aid and or ambulance service until a parent can be contacted.
Yes _____ No _____

In the event emergency treatment is necessary for my child and if we, the parents or the responsible adult indicated above, cannot be reached, the school authorities are authorized to take my child to a doctor or hospital for necessary treatment.

Parent's Signature _____Preferred hospital* _____

*In the event of an injury or accident away from school, the most convenient hospital will be used.

PARENTS/GUARDIANS PLEASE FILL OUT:

Are glasses or contact lenses necessary for study or athletics? _____

Allergic reactions (Please specify, foods etc.)_____

Is there any history of cerebral concussion, contusion, or skull fracture? _____

Any other injury or disease not mentioned previously? _____

The Queen City Academy Charter School
MEDICAL FORM

THIS FORM MUST BE COMPLETED BY THE DOCTOR/PEDIATRICIAN AND RETURNED BY SEPTEMBER 15th. *PLEASE NOTE THAT THE COMPLETION OF THIS FORM IS MANDATORY BEFORE THE STUDENT CAN PARTICIPATE IN ANY PHYSICAL ACTIVITIES.

Student's Name _____ Date of Birth _____ M _____ F_____

Parent/Guardian Name _____

Address _____
Street City State Zip

Phone _____ Alternate Number _____ Grade_____

Physician's Report of Physical Examination

Date of Examination _____

Height _____ Weight_____ Blood Pressure_____ Heart_____

Eyes _____ Ears _____ Teeth _____ Tonsils _____ Glands _____

Pulmonary _____ Orthopedic Deformities _____ Hernia _____

Hospitalizations _____Surgical History _____

Allergies _____Asthma _____ Medication _____

Any conditions not listed _____

Any restrictions or limitations for participation in QCACS Physical Ed. program? _____

IMMUNIZATION RECORD:

Dtap #1_____ #2_____#3 _____ #4 _____ #5 _____

Tdap Booster_____

Inactivated Polio (IPV) #1 _____ #2 _____ #3 _____ IPV Booster _____

MMR #1_____ #2 _____ Measles _____ Mumps _____ Rubella _____

Hepatitis A #1_____ # 2_____ Hepatitis B #1_____ #2 _____ #3_____

Varicella _____ Menactra _____ Tuberculin _____ Reaction _____

Chest X-ray _____ INH treatment _____ Other _____

Physician's Signature _____ **Date** _____

Physician's Stamp_____ **Phone #** _____

Physician's Address _____
Street City State Zip

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Medication Permission Policy

Dear Parents/Guardians:

If it is necessary for students to take medications during school hours, the following guidelines must be adhered to:

1) **A medication form must be submitted annually for children who require medication on a long-term basis.**

2) **A new medication form must be completed if there is a change in health status or medication regimen.**

3) **The parent/guardian must give permission for the school nurse or in her absence the principal or designee to administer medication.**

4) **The physician MUST specify the medication, dosage, frequency, route of administration, indication and the start-expiration date of the order.**

5) **The medication must be brought to the health office by the child or parent/guardian in its original container with the pharmacy label. The label must indicate the child's name, name of medication, dosage and frequency of administration.**

6) **A child may not keep medication on his/her person in the classroom, EXCEPT students requiring an inhaler for asthma attacks, Epi-pen or Auvi-Q (epinephrine injector for anaphylaxis), and students requiring insulin and glucagon injections. The Doctor must certify that a student is trained and capable to self medicate and demonstration must be observed by the nurse.**

<u>The above guidelines apply to both over the counter medicines and prescribed.</u>

The Queen City Academy Charter School
Medication Authorization Form

The top part is to be completed by the child's parent(s)/guardian(s). A new form must be completed every school year and returned to the health office along with the medication.

Student's Name:_____ Birth Date: _____

Home Phone Number:_____ Emergency Phone Number: _____

Parental Signature:_____

Teacher:_____ Grade: _____

To be completed by the student's physician, physician assistant or nurse practitioner

Physician's Printed Name: _____

Office Address:_____

Office Phone:_____ Emergency Phone_____

Medication Name & Dosage_____

Route: _____ Frequency_____

Purpose: _____

Time Medication is to be administered or under what circumstances:

_____

Length of time this treatment is recommended:_____

If medication is a metered dose inhaler is child allowed to carry on his/her person?_____

Physician's Signature:_____ Date:_____

Physician Stamp (**Mandatory**) :_____