CITY OF ELIZABETH, NEW JERSEY

DEPARTMENT OF HEALTH AND HUMAN SERVICES
50 WINFIELD SCOTT PLAZA, ELIZABETH, NEW JERSEY 07201
PHONE: (908) 820-4000 FAX: (908) 820-0112

OFFICE OF THE DIRECTOR
DIVISION OF HEALTH

J. CHRISTIAN BOLLWAGE
Mayor

Dear Parent(s),

It is the policy of the State of New Jersey that every enrolled student submit evidence of **Up-To-Date Immunizations** and a **Current Physical Exam** before entering school in September for the 2010-2011 school year.

Enclosed in this mailing is the Bruriah High School Medical Form. This entire medical form (5 pages following this letter) must be completely filled out - **incomplete forms will be returned**. All forms should be submitted to the school office no later than Orientation Day at the start of the school year.

Please note: if your daughter intends to participate in any school team sports activities, an additional much more detailed sports physical form must be completed. Your daughter **May Not Participate** in - or even try out for - any school team sports activities without first submitting that special form. **If you know your daughter intends to try out for a school sports team, as per NJ state regulations, you must complete a special "ATHLETIC PRE-PARTICIPATION" physical exam form instead of the attached. You may download it directly from the Bruriah website or call the Bruriah Office for a copy** (908-355-4850, x653).

Whichever form you submit, please be sure all pages are stapled together.

Also, please note that before a student can carry medication to school, a special form must be completed by the doctor and parent(s). This form is available from and must be returned to the school nurse's office.

Thank you for your prompt cooperation. If you have any questions, please feel free to call me at 908-355-4850, x324 once school begins.

Sincerely,
Bruriah School Nurse

MEDICAL EXAMINATION BY FAMILY DOCTOR

Each line must be addressed individually - DO NOT COPY LAST YEAR'S PHYSICAL EXAM!

PLEASE NOTE: IF YOUR CHILD INTENDS TO PARTICIPATE IN TEAM SPORTS AT SCHOOL, *ADDITIONAL HEALTH FORMS MAY NEED TO BE COMPLETED.*

STUDENT: ____________________________________ EXAM DATE: ___________________

(Exam must be no earlier than 6 months before start of school year)

SCHOOL: ____ GRADE: _________

DATE OF BIRTH _________________ WEIGHT ____________ HEIGHT: ____________

VISION CHECK: RIGHT EYE: 20 / ___________ LEFT EYE: 20 / ___________

CORRECTIVE LENSES WORN: ___________ DATE LAST CHANGED: ______________

HEARING CHECK: RIGHT EAR: _______________________ LEFT EAR: _______________________

ANY HEARING DIFFICULTY: ____

NOSE AND THROAT: ____________________________ TONSILS: ____________________________

ADENOIDS: _________________________ FREQUENT SORE THROAT: ________________________

THYROID: _________________________________ HEART: ___________________________________

TEETH: ____ LUNGS: _______________________________

LYMPH NODES: ___________________________ ABDOMEN: ________________________________

NUTRITION: ______________________________ ORTHOPEDIC: _____________________________

SKIN: ____ SPEECH: ______________________________

NERVOUS: ___________________________________ HERNIA: _________________________________

BLOOD PRESSURE: ___________________________ SCOLIOSIS: ______________________________

ANY SERIOUS INJURIES? ________ TYPE: ________________________________ AGE: _________

EXPLAIN: ____

ANY OPERATIONS? ________ TYPE: ______________________________________ AGE: _________

EXPLAIN: ____

ANY DISABILITIES? (If yes, please explain) ____

ASTHMA? _____________ MAY STUDENT PARTICIPATE IN ACTIVE SPORTS? ____________________

******ANY ALLERGIES?*** (to foods/meds - and what meds do you take _______________________________________

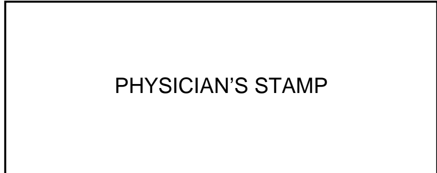
____

IMPORTANT! PHYSICIAN MUST TOTALLY COMPLETE THIS FORM.

PHYSICIAN'S NAME: ____

ADDRESS: ____

TELEPHONE NUMBER: ____



PHYSICIAN'S WRITTEN SIGNATURE: ______________________________ DATE: __________

CITY OF ELIZABETH, NEW JERSEY

DEPARTMENT OF HEALTH, and HUMAN SERVICES
PUBLIC HEALTH NURSING SERVICES
50 WINFIELD SCOTT PLAZA, ELIZABETH, NEW JERSEY 07201
PHONE: (908) 820-4250 FAX: (908) 820-4290

Please indicate below if your child has any allergies, either to foods or medicine. This is for the safety of your child while in school. If your child has a **SEVERE** allergy that requires an Epi-pen, the nurse MUST be notified because that is considered to be a life-threatening situation that can be avoided.

If your child needs to use a multi-dose inhaler for **ASTHMA**, it may be carried by the student, **PROVIDED** your physician and the parent complete the form: "Authorization for Self-Administration of Medication in School." If you have any questions regarding medication administration, please feel free to contact the school nurse.

NAME OF STUDENT; ____ GRADE: _____

ALLERGY TO MEDICINE: ____ YES ____ NO

IF YES, WHICH ONES: _______________________________________

SEASONAL ALLERGIES: ____ YES ____ NO

ALLERGIC TO BEE STINGS: ____ YES ____ NO

EPI-PEN (FOR EXTREME EMERGENCY): ____ YES ____ NO

ALLERGY TO FOODS: ____ YES ____ NO

IF YES, WHICH ONES: _______________________________________

EPI-PEN (FOR EXTREME EMERGENCY): ____ YES ____ NO

Does your child need to use an inhaler for **ASTHMA** while in school? ____ YES ____ NO

Does your child take medication every day for a medical condition? ____ YES ____ NO

If yes, please explain: ____

____

Is your child presently under a physician's care? ____ YES ____ NO

If yes, please explain: ____

____

PARENT SIGNATURE: ______________________________________ DATE: ___________

THANK YOU!
THE SCHOOL NURSE

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MEDICATION POLICY

REMINDER

1. ***Students are not allowed to carry medications***, with the exception of asthma inhalers and medications for anaphylaxis, and only after completion of the required forms by physician and parent/guardian.

2. Parent/guardian(s) are to administer medications at home whenever possible. Medication will be administered in school by the nurse only in exceptional circumstances wherein the child's health may be jeopardized without it.

3. Students requiring medication at school must have school medication forms completed by the physician and parent/guardian. All medications will be held and administered by the school nurse. If you want a student to self-administer, an "Authorization for Self-Administration of Medication in School" form must be completed and the student may then carry medicines. This form is available from the school nurse.

Your cooperation in adhering to this policy and enforcing it with your children is appreciated.

For questions and/or medication forms, please call the School Health Office.

Student Name: ____ Grade: __________

Please fill out this form and promptly return it to the school nurse.

Does the above named student above have any of the following:

	Please circle one	What medications are taken and how often? Additional Comments (Allergies, etc.)
ALLERGIES - TO WHAT?	Yes No	
ASTHMA	Yes No	
DIABETES	Yes No	
EPILEPSY/CONVULSIONS OR SEIZURES	Yes No	
SICKLE CELL	Yes No	
CHICKEN POX	Yes No	

Please list any additional medical problems we need to be aware of to provide adequate care:

____

____

____

____

____

Sincerely,
The Bruriah School Nurse

STUDENT NAME: ______________________________ DOB: ____________

ADDRESS: ____

CITY/ST/ZIP: ___________________________ HOME PHONE #: _____________

NAME OF PARENT(S): ____

IN CASE OF EMERGENCY, NOTIFY (OTHER THAN PARENTS):

NAME: _____________________________ RELATIONSHIP: ______________

ADDRESS: ___________________________ HOME PHONE #: _____________

CITY/ST/ZIP: _________________________OTHER PHONE #: _____________

NAME: _____________________________ RELATIONSHIP: ______________

ADDRESS: ___________________________ HOME PHONE #: _____________

CITY/ST/ZIP: _________________________OTHER PHONE #: _____________

IMMUNIZATION INFORMATION:

Vaccine Type	1st Dose	2nd Dose	3rd Dose	4th Dose	5th Dose	
DPT-DT-DtaP-Td-Tdap						
DTP/HIB						
POLIO						
MMR						
MEASLES						
MUMPS						
RUBELLA						
HIB						
HEPATITIS B						
VARICELLA						
MENACTRA						