Saddle Brook Public Schools
Saddle Brook, New Jersey 07663

EMERGENCY CONTACT

1. STUDENT INFORMATION

Name:_____

Address:_____

Home Tel. # _____ Birth Date: _____

Grade: _____ Teacher_____ School Year _____

2. PARENT/GUARDIAN INFORMATION:

Father's/Guardian's Name_____ Home Tel. #_____
Beeper #_____ Work Tel # with Ext. _____
e-mail _____ Cell # _____

Mother's/Guardian's Name_____ Home Tel. #_____
Beeper #_____ Work Tel # with Ext. _____
e-mail _____ Cell # _____

Parents or guardians listed above have permission to pick up the child, unless otherwise indicated. Notify the school principal immediately if there are any court orders restricting non-custodial parents or others from contact with the child. Provide the principal with a copy of the order.

3. CONTACTS DESIGNATED TO PICK UP MY CHILD IN AN EMERGENCY

A. Contact _____ Relationship to Child_____
Home Tel #_____ Work Tel # with ext._____
Cell #_____ Beeper #_____ e-mail_____

B. Contact _____ Relationship to Child_____
Home Tel #_____ Work Tel # with ext. _____
Cell #_____ Beeper #_____ e-mail_____

C. Contact _____ Relationship to Child_____
Home Tel #_____ Work Tel # with ext. _____
Cell #_____ Beeper #_____ e-mail_____

4. PHYSICIAN INFORMATION

Allergies to Food	Allergies to Medications	Any Other Allergies

Doctor's Name:_____ Tel #_____
Hospital Preference:_____
Insurance Company: _____
Dentist's Name:_____ Tel #_____

In a medical emergency, we hereby authorize the school district to seek emergency medical assistance for our child if we cannot be reached.

Parent/Guardian signature_____ Date _____

Please keep a copy of this form for your records. Important: Please update your school immediately if any information changes.

OVER

5. INSURANCE INFORMATION

Does Your Child Have Health Insurance?
Yes_____ If Yes, name of insurance company_____
No _____ NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information call 800-701-0710 or visit www.njfamilycare.org to apply online.

You may release my name and address to NJ FamilyCare to contact me about health insurance.

Signature:_____**Printed Name**_____**Date:**_____
Written consent required pursuant to 20 U.S.C. & 1232g (b)(1) and 34C.F.R. 99.30(b).

6. SIBLING INFORMATION

Please list other children attending New Jersey Public Schools (Name, School)

_____ _____
_____ _____
_____ _____
_____ _____

SADDLE BROOK PUBLIC SCHOOLS
MEDICAL HISTORY

TO BE COMPLETED BY PARENT/GUARDIAN:

Child's Name _____ Age _____ Grade _____

Family Physician _____ Phone _____

Has your child had the following?

	YES	NO	YEAR		YES	NO	YEAR
Chicken pox	___	___	_____	Diabetes	___	___	_____
Scarlet fever	___	___	_____	Convulsions	___	___	_____
Strep throat	___	___	_____	Asthma	___	___	_____
Rheumatic fever	___	___	_____	Hepatitis	___	___	_____
Mononucleosis	___	___	_____	Heart murmur	___	___	_____
Ear infection	___	___	_____	Other _____			

Any allergies? If so, what kind? _____

Any emotional problems/counseling? If so, what kind? _____

Any nutritional/eating problems? If so, what kind? _____

Any history of a speech problem? If so, what? _____

Dental problem? _____ Receiving treatment? _____

Hearing problem? _____ Receiving treatment? _____

Vision problem? _____ Receiving treatment? _____

Has your child had any:

	YEAR	EXPLAIN
Hospitalizations	_____	_____
Operations	_____	_____
Severe illness	_____	_____
Severe injuries (fractures, sprains, etc.)	_____	_____

Was birth and delivery normal? Yes_____ No_____ Birth weight _____
Caesarian_____ Instrument_____ Breech_____

Is your child presently under a doctor's care? If so, for what? _____

Does your child take any medications on a regular basis? If so, what kind? _____

Any other information that would assist us to help your child in school? _____

I do/do not (circle one) authorize the school nurse to release information to pertinent school personnel on health concerns/medical needs that might affect my child's safety or performance in the school environment.

Signature of Parent/Guardian _____ Date _____

SADDLE BROOK PUBLIC SCHOOLS
PHYSICAL EXAMINATION

Child's Name __________________________ Birthdate________ Age_____ Grade_____

TO BE COMPLETED BY PHYSICIAN:

HEIGHT________ WEIGHT________ BP________

EYES________ R 20/____ L 20/____ EARS________ HEARING R____ L____

LYMPH GLANDS/THYROID____________________ THROAT____________________

RESPIRATORY____

CARDIOVASCULAR____

ABDOMEN____________________ HERNIA____________________

GENITO-URINARY____________________ GENITALIA____________________

MUSCULOSKELETAL____________________ SKIN____________________

SCOLIOSIS SCREENING (If age appropriate)____________________

NEUROLOGICAL____

LABORATORY: URINALYSIS________ HGB/HCT________ OTHER________

RECOMMENDATIONS:

	YES	NO
1. Any defect of vision, hearing or speech that the school could compensate for by proper seating, etc.?	____	____
2. Any conditions limiting classroom activity?	____	____
3. Any conditions limiting physical education?	____	____
4. Any significant allergies? If yes, please specify____________________	____	____
5. Any condition which might result in a classroom emergency? If yes, please specify____________________	____	____
6. Any emotional, mental or physical condition requiring periodic medical observation?	____	____

COMMENTS:

VACCINE TYPE	1st Dose Mo/Day/Yr	2nd Dose Mo/Day/Yr	3rd Dose Mo/Day/Yr	4th Dose Mo/Day/Yr	5th Dose Mo/Day/Yr	LEAD SCREENING Test Date	Result
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination * (If Td or DT, indicate in corner box)							
Tdap							
POLIO -- INACTIVATED POLIO VACCINE (IPV) If oral vaccine, indicate (OPV) in corner box.							
MEASLES, MUMPS, RUBELLA (MMR)							
HAEMOPHILUS B (HIB)**							
HEPATITIS B							
VARICELLA							
PNEUMOCOCCAL CONJUGATE **							
MENINGOCOCCAL							
HEPATITIS A ***							
HPV (HUMAN PAPILLOMAVIRUS) ***							
OTHER							

Document below single antigen vaccine receipt, serology titers or varicella disease history		
Hepatitis B	Date	Titer
Varicella	Date	Titer
Measles	Date	Titer
Mumps	Date	Titer
Rubella	Date	Titer

☐ Provisional admission attached–Date Granted:__________ ☐ Medical exemption attached ☐ Religious exemption attached

MANTOUX________ RESULTS________

Physician's Signature______________________________ Date________

PLEASE PRINT NAME OR STAMP

Saddle Brook Public Schools

MEDICATION AUTHORIZATION FOR SEVERE ALLERGIC REACTION

For School Year _____

Student Name_____ DOB_____ Date_____

TO BE COMPLETED BY PHYSICIAN:

- If stung by_____
- After ingesting_____
- After exposure to_____
- Immediately give_____ whether or not symptoms are present. Medication/dose/route
- Give _____ if the following symptoms occur: Medication/dose/route

_____MOUTH: itching and/or swelling of lips, tongue, or mouth

_____THROAT: itching and/or sense of tightness in throat, hoarseness, hacking cough, and/or difficulty swallowing

_____SKIN: itching, hives, rash, and/or swelling in any area of body

_____GUT: nausea, abdominal cramps, vomiting, and/or diarrhea

_____LUNG: shortness of breath, sense of tightness in chest, repetitive coughing, and/or wheezing

_____HEART: rapid or weak pulse, dizziness and/or fainting

_____OTHER:_____

_____

STUDENT HAS HAD A DOCUMENTED EPISODE OF ANAPHYLAXIS: YES_____ NO_____

***IF EPINEPHRINE AUTO-INJECTOR IS PRESCRIBED, CHECK ONE:

_____Student is NOT capable of self-administration

_____Student IS capable of self-administration, has been instructed in medication use, and may carry epinephrine auto-injector and/or one dose of antihistamine with him/her.

***IF ANTIHISTAMINE IS PRESCRIBED TO BE GIVEN BY NURSE PRIOR TO EPINEPHRINE, PLEASE CHECK BELOW:

_____If a nurse and /or parent is not available during school or at any school sponsored event, and the student is having a severe allergic reaction, the antihistamine may be withheld and Epinephrine may be given by a trained delegate. (According to NJ State law, delegates may only administer epinephrine, not oral medications)

If epinephrine is given, EMS will be immediately contacted.

Physician's Signature_____ Date_____

Please print or stamp: Name_____

Address_____

Phone_____

TO BE COMPLETED BY PARENT/GUARDIAN:

I request that my child be given the medication described in the manner above at school by the school nurse. Only if authorized by the doctor, I request my child be permitted to carry an epinephrine auto-injector and/or one dose of antihistamine and self-medicate when necessary. If carried on his/her person, I will be cognizant of the expiration date and renew the injector when needed. I relieve the Board of Education and its employees of any liability which may result from the administration of the above medication to my child, or from self-administration when certified by the physician.

Parent/Guardian_____ Date_____

SADDLE BROOK PUBLIC SCHOOLS
AUTHORIZATION FOR MEDICATION TO BE TAKEN DURING SCHOOL HOURS

To be completed by Parent/Guardian:

Child's Name_____ Birthdate_____ Grade_____

Physician_____ Telephone_____

I request that my child be assisted in taking the medicine described below at school by the school nurse. I relieve the Board of Education and its employees of any liability which may result from administration of this medication to my child. (Medication must be brought to school in the original labeled container.)

Parent/GuardianSignature_____ Date_____

Home Phone_____ Emergency Phone_____

To be completed by Physician:

Diagnosis for which medication is given_____

Medication/Dose/Route/Frequency_____

_____

If given daily, at what time?_____

Give daily medication on field trips Yes_____ No_____
Give daily medication on half-days Yes_____ No_____

If given when needed, describe indications_____

_____

How soon can it be repeated?_____

Significant side effects_____

Length of time this treatment is recommended_____

Physician's Signature_____ Date_____

Please print name or stamp_____

SADDLE BROOK PUBLIC SCHOOL

Saddle Brook, NJ

RECOMMENDATIONS TO PREVENT SPREAD OF ILLNESS IN SCHOOL

STUDENTS SHOULD STAY HOME FROM SCHOOL IF THEY EXPERIENCE ANY OF THE FOLLOWING:

1. A bad cold/cough with a very runny nose or one that is draining yellow or green.
2. A fever of 100 degrees or higher. Students must be fever free for 24 hours before returning to school.
3. Student has vomited within the last 24 hours.
4. Student has had diarrhea within the last 24 hours.
5. Strep test that is positive. Student must be on antibiotics for 24 hours before returning to school.
6. Redness of the whites of the eyes with yellow discharge and matted eyelashes.
7. Rashes that are blistery, oozing or sore and are of unknown origin.