CHILD FAMILY CENTER
Nurse Health Registration Form

Dear Parent/Guardian:

The school nurse's office is open from 8:00 AM to 4:00 PM daily. The health services provided for all students are: Height, Weight, Dental, Hearing, Vision and Blood Pressure Screenings.

The non-prescription medications which are available to all students with approval of the school physician are: Chloraseptic throat spray, Anbesol, Vaseline, Sting Kill, 0.5% hydrocortisone ointment, eye wash, sterile saline, Polysporin ointment and burn gel.

If your child requires prescription or non-prescription medication on a regular basis, you must obtain a written order from your child's physician on the school medication administration form and you will need to supply the medication and sign the form giving the school nurse permission to give the medication.

Please complete the Student Health History and return it to the school nurse so we can update your child's health records. This information will be shared with your child's teacher, administration, and other staff on a need to know basis unless a written note is received from you requesting it be kept confidential.

If you have any questions regarding the health services provided, please call us at 856-293-2178/2177. We look forward to this school year and hope we can be of help to you and your child.

Sincerely,

Karen Chamenko, RN, BA, CSN
Leonarda Tamagni, RN, BA, CSN
REQUIRED IMMUNIZATIONS
NEEDED FOR
PRE-SCHOOL 3 & 4 YEAR OLDS:

DTaP – 4 DATES
POLIO – 3 DATES
MMR – 1 DATE AFTER 1\textsuperscript{ST} BIRTHDAY
HIB – 1 DATE AFTER 1\textsuperscript{ST} BIRTHDAY
PCV – 1 DATE AFTER 1\textsuperscript{ST} BIRTHDAY
VARIVAX – 1 DATE AFTER 1\textsuperscript{ST} BIRTHDAY
OR WRITTEN PROOF OF CHICKEN POX DISEASE
FLU BETWEEN 9/1 & 12/31 EACH YEAR

COMPLETE HEALTH HISTORY FORM

*PHYSICAL EXAM BY DOCTOR
OR NURSE PRACTITIONER

*A CURRENT PHYSICAL EXAM MUST BE SUBMITTED
WITHIN 30 DAYS OF START DATE TO BE ACCEPTED AS
CURRENT

FREE PHYSICALS ARE OFFERED AT REGISTRATION

ALL RECORDS MUST BE SIGNED AND STAMPED BY
PHYSICIAN

RECOMMENDED IMMUNIZATIONS:
HEPATITIS B SERIES
MILLVILLE PUBLIC SCHOOLS

DISCRETIONARY MEDICATIONS

The medications identified below may be administered to your child at the discretion of the Certified School Nurse or her substitute in accordance with established protocols developed by the School Physician for grades Preschool – 12 during the entirety of their Millville Public School career. In some instances, a generic equivalent may be used.

For cough/sore throat: Throat spray (Chloraseptic) and/or Cough drops/lozenges

Note: Students in grades 6-12 are permitted to carry and self-administer cough drops/lozenges.

For toothache due to caries, erupting teeth, irritated gums, canker sores: Anbesol

For fever blisters (herpes simplex): Camphophenique/Carmex

For dry/chapped lips: Vaseline/petrolatum

For insect bites, itching skin, minor skin irritations: Sting Kill and/or hydrocortisone cream

For foreign body in eye/contact lenses: Sterile saline or Dacriose eyewash

For severe brush burns, abrasions, minor lacerations: Polysporin ointment

For minor first and second degree burns: Burn gel

In the event that you do not want your child to receive any or all of the medications listed above, please put your request in writing and provide it to the Certified School Nurse at the school attended by your child.

Thank you.
BLOOD LEAD SCREENING FORM

To be completed by the Parents/Guardians

Child’s Information:

Name: ____________________________    Birth Date: ________________

Address: ____________________________

Telephone Number: (____) ______________

Parent’s/Guardian’s Name: ____________________________

Child Care Center Information:

Name: ____________________________    Address: ____________________________

Telephone Number: (____) ______________

To be completed by the Child’s Health Care Provider

Health Care Provider’s Information:

Name: ____________________________

Address: ____________________________

Telephone Number: (____) ______________

Blood Lead Screening(s)

<table>
<thead>
<tr>
<th>Date</th>
<th>Age</th>
<th>Comments</th>
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<tbody>
<tr>
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</table>

Health Care Provider’s Signature: ____________________________    Date: ________________

Parents/Guardians: Please return this completed form to your Child Care Center

FD-407 (rev.7/04)
# Universal Child Health Record

## SECTION I: TO BE COMPLETED BY PARENT(S)

<table>
<thead>
<tr>
<th>Child's Name (Last)</th>
<th>Gender</th>
<th>Date of Birth</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>Does Child Have Health Insurance?</th>
<th>If Yes, Name of Child's Health Insurance Carrier</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Parent/Guardian Name</th>
<th>Home Telephone Number</th>
<th>Work Telephone/Cell Phone Number</th>
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<tbody>
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</table>

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.

## SECTION II: TO BE COMPLETED BY HEALTH CARE PROVIDER

<table>
<thead>
<tr>
<th>Date of Physical Examination:</th>
<th>Results of physical examination normal?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
</tbody>
</table>

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 signs/symptoms to watch for:
  - None
  - Special Care Plan Attached
  - Comments

## PREVENTIVE HEALTH SCREENINGS

<table>
<thead>
<tr>
<th>Type of Screening</th>
<th>Date Performed</th>
<th>Record Value</th>
<th>Type of Screening</th>
<th>Date Performed</th>
<th>Note If Abnormal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hgb/Hct</td>
<td></td>
<td></td>
<td>Hearing</td>
<td></td>
<td></td>
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<tr>
<td>Lead</td>
<td>Capillary</td>
<td>Vision</td>
<td>Dental</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Venous</td>
<td></td>
<td>Developmental</td>
<td></td>
<td></td>
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<tr>
<td>TB (mm of Induration)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Scoliosis</td>
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<tr>
<td>Other</td>
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<tr>
<td>Other</td>
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</table>

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 childcare/school activities, including physical education and competitive contact sports, unless noted above.

Name of Health Care Provider (Print)

Signature/Date

Distribution: Original-Child Care Provider  Copy-Parent/Guardian  Copy-Health Care Provider
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, 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 issues 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 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 health 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.