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	

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 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 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 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 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.

PILLARS
PREPARATORY ACADEMY

PILLARS PREPARATORY ACADEMY

A Strong Foundation for Success

MEDICATION ADMINISTRATION POLICY

Dear Parent/Guardian,

If would like to take this time to explain the policy for dispensing medications at school and make you aware of the following:

- Students are not permitted to carry medications in school. (Except inhalers & epi-pens with Written order from your physician).
- **MEDICATIONS SHOULD BE GIVEN AT HOME, IF AT ALL POSSIBLE.**
- The policies of the Educational Services Commission of New Jersey and the State of New Jersey requires that any medication to be given in school must be accompanied by a **Written order form** from your physician. A form is attached for your use. This form must be completed for **all types** of medication prescription and non-prescription i.e., inhalers antibiotics, Tylenol, etc. This form must be signed by the physician and dated. (Duplicate the form, if necessary, or request extra copies from the school office).
- The medication must be given to the school nurse in a **pharmacy labeled** container which includes the nae of the **student, expiration date**, name and telephone number of the pharmacy, the prescription number, the **name and dosage of the medication the directions for administering the medication and the time it is to be dispensed** at school along with the name of the physician who prescribed the medication.
- Medication Orders need to be renewed with every school year.

New Jersey State Law requires that all medication be kept in the nurse's office for the safety of all the children. Inhalers are included in these items.

Along with the physician's form, a parent's / guardian's form must also be completed and signed, giving permission for the prescribed medication to be administered in school. The only alternative to the above policy would be for one parent / guardian to come to the school to administer the medication to the child personally.

The school **must have** the parent's / guardian's cell phone, work phone, home phone number and two emergency contact numbers on file. The form you filled in at the beginning of the year should have this information. If **any** of these numbers change during the school year, please notify the school immediately. We must be able to reach someone quickly in an emergency.

In addition, we would like to remind you to phone in all illnesses and absences to the school office. It is extremely important that diseases or injuries be promptly reported to the school. Please submit any Health-related correspondence to NURSE / CONFIDENTIAL. Your cooperation in this area will be greatly appreciated.

I wish everyone a successful school year. If you have any concerns, please feel free to call me anytime at (732) 390-4200.

School Nurse

Donna Uszal R.N.

PILLARS PREPARATORY ACADEMY

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EDUCATIONAL SERVICES COMMISSION of NEW JERSEY

SCHOOL YEAR 2022-2023

TO: **Parent/Guardian**

FROM: **Pillars Preparatory Academy**

RE: **Nursing Services; Chapter 226 - Laws of 1991**

Existing legislation provides certain nursing services and funding for full time students in private schools.

Included in these services, based on available state aid, is maintenance of student health records, hearing assessment, and scoliosis screening.

In addition, your child will receive emergency nursing services for any school related illness or injury.

Please sign the form below and return it to my office as soon as possible.

NONPUBLIC NURSING SERVICES

____I do give my permission

____I do **NOT** give permission

for my child____, in grade ___________
(Please Print Child's Name)
to participate in nursing services.

____
School District

Pillars Preparatory Academy
Name of School

34 Charles Street, South River, NJ 08882
School Address

____ ____________________
Signature of Parent/Guardian Date

PILLARS PREPARATORY ACADEMY

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Name of School

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School Address

____ ________________
Signature of Parent/Guardian Date

PILLARS PREPARATORY ACADEMY

A Strong Foundation for Success

MEDICAL UPDATES

School Year ________

Parents, Please Complete and Return

Student's Name: ______________________________ Grade: ____________

Health Information & Consents

Allergies My child is allergic to: ______________________________

____

My child uses an EPI-PEN: ☐ **YES** ☐ **NO**

Asthma: My child has asthma, diagnosed by a physician: ☐ **YES** ☐ **NO** My child carries an inhaler in school (see required form if YES) ☐ **YES** ☐ **NO**

Medication My child takes the following medication(s): ______________________________

____

My child takes the following medication(s) in school: ______________________________

____

Medical My child has the following medical condition(s): ______________________________

I give consent for my child to receive: ☐ **Acetaminophen** ☐ **Ibuprofen**

Sharing Medical Information

I give consent for my child's medical information to be shared when necessary, with school personnel to insure proper care and treatment while my child is participating in school activities.

______________________________ ______________

Parent / Guardian Signature Date

Illnesses / Accidents / Hospitalizations Within the Last Year

____

____

Please be advised that if your child requires medication while in school you must have a doctor's order along with Parent's consent as required. This includes ALL medication including over the counter medication (See policy).

If your child needs to be excused from physical education for an extended period, a note from your physician is required indicating reason an amount of time for exclusion.

School Nurse

Quratulain Azam
BSN,RN