SUSSEX COUNTY
CHARTER SCHOOL FOR TECHNOLOGY

385 N. Church Rd. Sparta, NJ 07871 (973) 383-3250 (973) 383-2901 (fax)

Noreen Lazariuk, *Superintendent*
nlazariuk@sussexcharter.org

Dear Parents and Guardians,

Every year the following health forms must be filled out by a parent or guardian for each Sussex Charter student.

1. **Student Emergency Information**
2. **Student Health History**
3. **Medication Dispensing Form**

Kindly return the completed forms to school as soon as possible.

Please note that in addition to filling out the forms listed above, all new students are required to have a physical before entering school. Please have your health care provider send a copy to school as soon as possible.

If you have any questions or concerns please feel free to contact me.

Thank you,

Colleen Puhala, BSN, RN, CSN
cpuhala@sussexcharter.org
Phone: (973) 383-3250 x2
Fax: (973) 383- 2901

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STUDENT EMERGENCY INFORMATION **CIRCLE Number to Call First in an Emergency**

Complete One per Family per School Year

Grade _____

Student's Last Name_____ First Name_____

Address_____

Home Phone _____

Mother/Guardian_____ Father/Guardian_____

Employer_____ Employer_____

Work Phone_____ Work Phone _____

Cell Phone_____ Cell Phone _____

Person to Notify if Parent Cannot be Reached:

Name_____ Name _____

Phone _____ Phone _____

Relationship _____ Relationship _____

Family Physician _____ Phone _____

Family Dentist _____ Phone _____

TURN OVER

Does this child have any health insurance including NJ Family Care/Medicaid, private or other?
____ Yes Name of the Insurance Company:_____
____ No NJ Family Care 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.njfamilycae.org to apply online.

You may release my name to the NJ Family Care Program to contact me about health insurance.

Signature:_____Printed Name:
_____

Date: _____
Written consent required pursuant to 20U.S.C. § 1232G (B) (1) AND C.F.R. 99.30 (b)

In case of an accident or serious illness, the school will make every effort to contact the parent/guardian. If the school is unable to reach the parent/guardian, the school will make every effort to call the physician listed above (or school physician if the listed physician is unavailable) and to follow his/her instructions. If it is impossible to contact this physician, the school will make whatever arrangements are necessary.

I hereby release the school from claim arising out of the physician's actions, and I assume and agree to pay the physician's charges for services and any charges incurred at the physician's direction.

Parent/Guardian Signature_____

Date: _____

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STUDENT HEALTH HISTORY

Complete One per Student per School Year

Grade _____

Student's Last Name_____ First Name_____

Phone Number to call FIRST in Emergency:_____

Does your child have a medical/health condition that the school should be aware of?

_____

_____

_____

Is your child currently under a doctor's care? Please specify reason:

_____

_____

_____

Is your child currently taking medications? Please specify:

_____

_____

_____

Is your child allergic to any of the following? Please specify reaction and treatment.

Medications:_____
Bees/Insects:_____
Foods: _____
Other: _____

I give permission for the School Nurse to share this information with my child's teacher(s).

Parent/Guardian Signature_____

Date: _____

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Medication Dispensing

For the safety of all pupils, students are not permitted to carry and self-administer any over-the-counter or prescription medications without the written directions of their private physician. The consent for self-administration of medications will only be granted for life threatening illnesses such as anaphylaxis, asthma and diabetes. All other over-the-counter and prescription medications require a physicians written order AND parent/guardian's written consent before the medication can be administered by the School Nurse. **This applies to all students, regardless of their age.**

In the event of a minor medical problem, the following medications have been approved by the School Physician to be administered by the School Nurse. Parent/Guardian signature is required in order for the nurse to administer these medications to your child. Parental permission is valid for the current school year only.

Acetaminophen (Tylenol), 325 mg. 2 Tablets, no more than once a day

Cough Drops/Throat lozenges, up to 4 per day

Tums, 1-2 tablets, no more than once per day

Student Name: _____ Grade:_____

Parent/Guardian Signature: _____

Date: _____

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HEALTH OFFICE NEWSLETTER

EMERGENCY INFORMATION AND MEDICATION PERMISSION

Enclosed are the Emergency Information and Student Health History forms that need to be completed on a yearly basis, one per family and one per student, respectively. It is extremely important that you provide us with any information that may be needed in an emergency situation. Please complete *ALL* forms and return them to the Health Office as soon as possible. Please call the Health Office with any changes to your emergency information during the school year, i.e. change of phone number, address.

MEDICATION POLICY

For the safety of all our pupils, students are NOT permitted to carry and self-administer ANY over-the-counter or prescription medications without the written directions of your private physician. Consent for self-administration of medication is only granted for life threatening illnesses such as allergic reactions, asthma or diabetes.

All prescription and over-the-counter medications require a physician's written order AND the parent/guardian's written consent before any medication may be administered by the School Nurse. This applies to all students regardless of their age. Written consent must be provided every school year.

Appropriate forms for medication administration and authorization for self-administration are available in the Health Office.

HEALTH SCREENING

Your child may participate in the following school health services, as mandated by the State of New Jersey Department of Education:

Vision screening- Grade 6 & 8

Hearing screeing- Grade 7

Height & Weight- Grade 6, 7 & 8

Scoliosis screening- Grade 6 & 8

Sussex County Charter School for Technology
Medication Administration during School/Field Trips

This form must be completed fully in order for the school to administer required medication. A new medication administration form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or time of administration of a medication.

*Prescription medication must be in a container labeled by the pharmacist or provider.
*Non-prescription medication must be in the original unopened container with the label intact.
*An adult must bring the medication to the school.
*The School nurse (RN) will call the prescriber, as allowed by HIPPAA, if a question arises about the medication.

Prescriber's Authoriziation

Student Name:_____ DOB:_____

Condition for prescribed medication:_____

Medication Name:_____

Dose:_____ Route:_____

Time/Frequency of administration:_____

Side Effects:_____

End Date:_____

____ I certify that the above named student is capable of and has been instructed in the proper administration of this medication. I recommend this student be allowed to carry and self-administer this medication for his/her life threatening condition. (NJSA 18A:40-12.3)

____ Student is not capable of self-administering medication for his/her life threatening condition and requires assistance.

____ This medication is not for a life threatening condition. Medication shall be held and dispensed by the school nurse or RN.

Physician Signature: _____ Date:_____

Physician's Stamp

Parent/Guardian Authorization

I give my permission for the above medication to be administered to my child, either by self-administration or administration by the school nurse or (RN), as indicated by the above physician. I certify that I have legal authority to consent to medical treatment for the above named student, including the administration of medication at school/field trip. I understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I authorize the school nurse or (RN) to communicate with the healthcare provider as allowed by HIPAA. I hereby relieve the Board and its employees of any and all liability that may result from the administration, either by self-administration or administration by the school nurse or (RN), of this medication to my child.

Parent/Guardian Signature:_____ Date:_____

Cell Phone:_____ Work Phone:_____