Edgarton Christian Academy

P.O. Box646, 212 Catawba Ave.,
Newfield, NJ 08344
856-697-7300
856-697-7303
www.eca-pk8.org

SCHOOL YEAR 2020-2021
ONE PER STUDENT
ALL GRADES PK TO 8TH

Dear Parent/Legal Guardian:

Enclosed is the Beginning of the Year Health and Emergency Information packet for your child. Please fill out each form **carefully and completely**.

I. HEALTH CONDITIONS, MEDICATIONS, AND UPDATES

Please indicate in the appropriate area any health related illnesses or conditions your child has and what medications your child is taking. Also, please indicate if your child has received any immunizations since last school year. If so, an updated record of immunizations from your child's health care provider is needed to keep the student's file up to date.

II. HEALTH SCREENINGS PERMISSION FORM

Explains the health screenings provided by your nonpublic school nurse.

III. MEDICATION ADMINISTRATION

If your child requires medication at school then several state regulations must be followed. This applies to both prescription and non-prescription medications (Benadryl, Tylenol, Robitussin, over-the counter, etc…) medications. **Please note NO MEDICATIONS ARE STOCKED at school for administration to students. Any medication must be physician ordered and provided by the parent/legal guardian.**

Children are not permitted to transport medicine. Parent/legal guardian or responsible adult must transport medications to and from school.

IV. PHYSICIAN MEDICATION ORDER FORM

This must be utilized when a medication is required for your child during the school day.

V. REQUEST FOR SELF-ADMINISTRATION OF MEDICATION

This must be utilized when requesting self-administration of medication for your child during the school day.

Let's have a safe and healthy school year!

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HEALTH CONDITIONS, MEDICATIONS, AND UPDATES

Student Name: _____ Grade _____ Date _____

Please complete the following information and forward to the school nurse as soon as possible. If a condition exists, please supply information about the conditions(s). Specify what action, if any, is required at school. Please remember the administration of any medication requires a physician's note. This information will be kept with the student's health records and kept confidential.

CHECK THE CONDITION, TREAMENT ACTIVCITY, LIMITATIONS, AND CURRENT NEEDS THAT APPLY TO YOUR CHILD.

_____ Asthma _____

_____ Allergies _____

_____ Ear Infections _____

_____ Eye/Vision Problems _____

Wears glasses ___ Yes ___ No Wears contacts ___ Yes ___ No

_____ Skin Problems _____

_____ Mouth/Nose/Throat Problems _____

_____ Respiratory Problems _____

_____ Heart Problems _____

_____ Stomach Problems _____

_____ Urinary/Bowel Problems _____

_____ Bone/Muscle Problems _____

_____ Emotional Stress _____

_____ Diabetes: Insulin Amount and Times: _____

Snack required ___ Yes If yes, what time_____ ___ No

_____ Seizures (convulsions)

___ Nonclonic/nontonic _____

___ Clonic/tonic _____

___ Psychomotor _____

_____ Medications routinely given: 1. _____

2. _____

3. _____

4. _____

_____ Surgery _____

Please list any comments you feel necessary regarding your child's health or behavior.

_____

PLEASE RETURN THIS FORM TO THE SCHOOL NURSE WITH YOUR EMERGENCY MEDICAL CARD WITHIN TWO DAYS.

Also, in order to provide the best possible care for your child, please notify the school nurse with a note from you and your physician, at any time there is a health update.

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HEALTH SCREENING PERMISSION FORM

Dear Parent/Legal Guardian:

Listed below are the health services to be offered to the students this year. If you **do not** wish for your child to receive any or all of these services please inform us in writing within 2 weeks. Thank you.

TYPES OF SCREENINGS:

*** Blood Pressure, Height, and Weight (Grades K-8)**

*** Vision Screening (Grades K-6 and 8)**

And students referred by Child Study Team or at the request of a parent, teacher, or self

*** Hearing Screening (Grades K-4, 6 and 8)**

And students entering with no record of hearing screening, at risk for impairment or noise exposure, students referred by the Child Study Team or at the request of a parent, teacher or self.

*** Scoliosis Screening (Grades 5 and 7)**

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SCHOOL YEAR 2020-2021
MEDICATION ADMINISTRATION
IN SCHOOL REGULATIONS REGARDING MEDICATION

Medication shall be administered in school only by a written order by the prescribing physician, along with a written request and a supply of medication from the parent/legal guardian. All medication must be properly labeled, in the original pharmacy container and brought to school by the parent/legal guardian. Any unauthorized medication found in the student's possession without proper documentation on file, will be taken and held in the school office, and the parent/guardian notified. This is for the safety of your child and others.

Medication in general, according to state law, will be administered or taken under the supervision of the school nurse. **Please note a school nurse may not always be available during school hours to administer medication.** Contact the school office to obtain times and days the nurse is assigned. Therefore, receipt of a doctor's note and written request from the parent does not guarantee that a medication can be administered during the school day.

A medication order is effective from July 1 to June 30 of each school year and must be renewed annually.

In the case of a **POTENTIALLY LIFE-THREATENING CONDITION** (i.e. epinephrine/inhaler usage), legislation has been passed which allows a student to carry a medication for immediate availability and self-administration. However, this situation **REQUIRES** proper documentation. Contact the school nurse in order to obtain the appropriate documents. In the case of a student with a potentially life threatening allergy, with documented history of an actual anaphylactic episode, provision of a nurse-trained designee for administration of emergency epinephrine, in the event a nurse is unavailable, is allowable under law. However, certain restrictions apply and you must contact the school nurse.

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PHYSICIAN MEDICATION ORDER FORM PER GLOUCESTER COUNTY

Signed Original Order Required

Student Name: _____ Grade: _____ DOB:_____

Non Public School _____

Please provide a separate form for each medication that is to be administered.

***PHYSICIAN TO COMPLETE:**

Diagnosis: _____

Medication: _____ DC Date:_____

Dosage: _____ Route: _____ Time: _____

Special Instructions: _____

Precautions/Side Effects: _____

_____

Date: _____ Physician Signature: _____

Original signature/No stamps please

PHYSICIAN NAME_____
ADDRESS_____
PHONE NUMBER_____

***Please note: A GCSSSD nurse is not always available during school hours to administer this medication. Please contact the school principal to determine the manner in which medication will be dispensed in the absence of a GCSSSD nurse.**

A medication order is effective July 1-June 30 of each school year and must be renewed annually.

I give permission for _____to receive medication above at school as prescribed by Dr._____.

I WILL BRING THE MEDICATION (PRESCRIPTION OR NON-PRESCRIPTION) TO SCHOOL IN THE ORIGINIAL CONTAINER, PROPERLY LABELED, AND WILL PICK UP ANY UNUSED MEDICATION. STUDENTS ARE NOT PERMITTED TO CARRY MEDICATIONS TO OR FROM SCHOOL.

_____ _____

Date Parent/Legal Guardian Signature

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SCHOOL YEAR 2020-2021
REQUEST FOR SELF-ADMINISTRATION OF MEDICATION

Student Name: _____ D.O.B._____ Date: _____

Grade: _____ Teacher: _____

PARENTAL REQUEST

I, the parent/guardian of _____, authorize the Principal and School Nurse to permit the student to self-administer the prescribed medication as indicated. I understand and agree that the school, school nurse and principal shall incur no liability as a result of any injury arising from the self-administration of medication by the student and I hold harmless the school, school nurse, and principal against any claims arising out of the self-administration of medication by the student.

I agree to bring a weekly supply of the medication to the school nurse. The medication will be brought to school in its original container appropriately labeled by my pharmacy.

_____ _____
Signature of Parent/Guardian **Date**

_____ _____
Address **Phone Number**

PHYSICIAN'S STATEMENT

In order to protect the health of _____ it is necessary for him/her to have the following medication during school hours.

MEDICATION: _____

DOSAGE: _____

TIME TO BE ADMINISTERED: _____

LIST ANY POSSIBLE SIDE EFFECTS WHICH MIGHT BE EXPECTED:

_____

DIAGNOSIS: _____

I request that the student be allowed to carry and self-administer the prescribed medication. I certify that the student is capable of, and has been instructed in the proper methods of self-administration.

_____ _____
Signature of Physician **Date**

_____ _____
Print/Stamp Physician Name **Phone Number**