

**THE BRIDGE ACADEMY**

1958-B Lawrenceville Road  
Lawrenceville, NJ 08648  
Phone: 609-844-0770 Fax: 609-844-0773  
www.banj.org

Dear Parent/Guardian,

Summer 2018

Welcome to The Bridge Academy and the 2018-2019 school year. Please read the following information carefully, as some of the information has changed. State Law now requires that the Tdap & Menactra immunizations be given at age 11. Written certification must be forwarded to the Health Office when these immunizations are given.

**New Students:** A copy of an updated immunization record by the child's physician plus a copy of the A45 record located in the Nurse's Office of your child's previous school is needed.

I can get this record with a signed permission from the parent or guardian.

**Physical Form:** Physicals are required on all new students and need to be updated every 1 to 2 years.

**Health History Form:** A Health History form needs to be completed & returned.

**Tylenol Form:** A standing order from our school physician allows Tylenol to be given to your child while they are in school.

**Medication Form:** A medication form needs to be completed by a physician to administer any prescription or over the counter medicine while in school.

**Epipen or Asthma Medications:** A Medication Administration form for **Asthma Inhaler or Epipen ONLY** must be completed by the physician along with an Asthma Treatment Plan or Epipen use for Severe Food & Bee/Insect Sting Allergy Action Plan.

**Returning Students:** The following forms need to be updated and returned to the Health Office during the first week of school in September.

**Health History Form**

**Tylenol Medication Form**

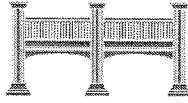
**Private Physical Form & updated immunization records from the physician**

**Medication Form** A medication form needs to be completed by a physician to administer any prescription or over the counter medicine while in school.

**Epipen or Asthma Medication Form** A Medication Administration form for **Asthma Inhaler or Epipen ONLY** must be completed by the physician along with an Asthma Treatment Plan form or Epipen Use for Severe Food & Bee/Insect Sting Allergy Action Plan form.

All forms are available on the website to print out.

Thank You,  
Bernadette Alexander RN, BSN, CSN  
School Nurse



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**HEALTH HISTORY**

**18-19 School Year**

**Dear Parent/Guardian:**

We would like your child to gain the most from his or her school experience. In order to assist us, it is necessary for you to complete & return a current health history for this current school year.

**Student's Name** \_\_\_\_\_ **Age** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

1. Does your child have any allergies? Please include medication, bee stings, insect bites, food & environmental or seasonal allergies. Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, list the allergy, type of reaction, & treatment.

\_\_\_\_\_

2. Does your child have any medical concerns such as asthma, diabetes, heart disease, seizure disorder, neurological disease, migraines, hearing loss, other? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain.

\_\_\_\_\_

3. Does your child wear glasses? Yes \_\_\_\_\_ No \_\_\_\_\_ Contact Lenses? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, list whether they are for reading, board work, or both.

\_\_\_\_\_

4. Does your child wear a hearing aid? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, Right Ear \_\_\_\_\_ Left Ear \_\_\_\_\_ Both \_\_\_\_\_

5. Has your child had any recent injuries or surgeries? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain.

6. Does your child have any restrictions? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain.

\_\_\_\_\_

7. Please list **ALL MEDICATIONS** that your child is taking. Include med name, dose, & time of administration.

\_\_\_\_\_

\_\_\_\_\_

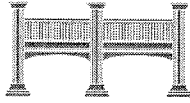
Please list anything that would be helpful in meeting the health & educational needs of your child.

I give my permission for my child to have cough drops, as needed, while at school. **Please Initial** \_\_\_\_\_

I give my permission for the release of information on this form for confidential use in meeting my child's health & educational needs while attending The Bridge Academy.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date



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**TYLENOL (Acetaminophen) Administration Form**

Student \_\_\_\_\_ Date of Birth \_\_\_\_\_

**PARENTAL REQUEST**

I give permission for the administration of Tylenol (Acetaminophen) to the above named student.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

**PHYSICIAN'S STATEMENT**

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

**DIAGNOSIS:** Pain or Fever

**MEDICATION:** Tylenol (Acetaminophen)

**DOSAGE:** As per package directions

**TIME TO BE ADMINISTERED:** Every 4 hours (PRN)

**PURPOSE OF MEDICATION:** Alleviate pain or reduce fever

**POTENTIAL SIDE EFFECTS:** None

**DATE TO BEGIN/CONCLUDE:** 2018-2019 School Year (9/1/18-6/30/19)

\_\_\_\_\_  
Signature of Physician

\_\_\_\_\_  
Print Physician's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Address

\_\_\_\_\_

# Private Medical Examination Report

Student \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_

**1. Immunizations:** Please indicate exact month, day, and year

DPT or Td	Polio	HIB	MMR	Hep B	Tuberculin Test
1. _____	1. _____	1. _____	_____	_____	Type _____
2. _____	2. _____	2. _____	_____	_____	Result _____
3. _____	3. _____	3. _____	Measles _____	Varicella _____	BCG _____
B. _____	B. _____	_____	Mumps _____	Varicella _____	
B. _____	B. _____	_____	Rubella _____		
Tdap _____	Menactra _____			Hep A _____	Hep A _____

**PUPIL'S HEALTH HISTORY**

**\*\*Conditions Requiring Medical Attention**      **\* Family History**

Allergies _____	Lyme's Disease _____
Asthma _____	Mononucleosis _____
Diabetes _____	Operations _____
Drug _____	Otitis Media _____
Sensitivities _____	Rheumatic Fever _____
Heart Disease _____	Seizure Disorder _____
Injuries _____	Other _____

A. History of Surgery \_\_\_\_\_  
 \_\_\_\_\_

B. Evidence of hearing or visual difficulty \_\_\_\_\_  
 \_\_\_\_\_

C. Description of condition requiring attention \_\_\_\_\_  
 \_\_\_\_\_

D. Recommendations \_\_\_\_\_  
 \_\_\_\_\_

E. Restrictions \_\_\_\_\_  
 \_\_\_\_\_

**EXAMINATION** – To be completed by the physician

Ears \_\_\_\_\_

Eyes \_\_\_\_\_

Nose \_\_\_\_\_

Throat \_\_\_\_\_

Mouth \_\_\_\_\_

Neck \_\_\_\_\_

Lymph Nodes \_\_\_\_\_

Thyroid \_\_\_\_\_

Heart \_\_\_\_\_

Chest Contour \_\_\_\_\_

Lungs \_\_\_\_\_

Abdomen \_\_\_\_\_

Hernia \_\_\_\_\_

Genito-Urinary \_\_\_\_\_

Orthopedic

Scoliosis \_\_\_\_\_

Structural \_\_\_\_\_

Posture \_\_\_\_\_

Feet \_\_\_\_\_

Skin \_\_\_\_\_

Nutrition \_\_\_\_\_

Nervous System \_\_\_\_\_

Speech \_\_\_\_\_

Other \_\_\_\_\_

General Appearance \_\_\_\_\_

B/P \_\_\_\_\_

Height \_\_\_\_\_

Weight \_\_\_\_\_

Any other special recommendations to the school nurse and teacher to benefit the student's physical & emotional well-being

\_\_\_\_\_

\_\_\_\_\_

Physician \_\_\_\_\_  
 (Print or Type Name)

Address \_\_\_\_\_  
 \_\_\_\_\_

Physician's Phone Number \_\_\_\_\_

Date of Examination \_\_\_\_\_

\_\_\_\_\_  
 (Signature of Physician)

PLEASE RETURN THE COMPLETED FORM TO THE SCHOOL NURSE

Religious Objection to Immunization

Child's Name \_\_\_\_\_ DOB \_\_\_\_\_

Parent's Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/ZIP \_\_\_\_\_

School \_\_\_\_\_

Address \_\_\_\_\_

City/State/ZIP \_\_\_\_\_

Dear School Officials:

We hereby certify that the administration of vaccine and other immunizing agents to our child, \_\_\_\_\_, conflicts with the tenets and practice of a recognized religion, of which we are adherents. We therefore request that our child be exempted from the school immunization requirements.

We are aware that in the event a student of the school acquires a vaccine preventable communicable disease, we will receive notification and our child we be excluded from school for a time period recommended by the local Department of Health.

We are aware that in the event our child receives ANY vaccination subsequent to this notification, all previous religious exemption requests will be considered void, and all deficient vaccines will be required.

We are aware that religious exemptions must be renewed annually.

We are informed of and we fully understand the risks and benefits of non-immunization for our child. We swear that all of the foregoing statements are true to the best of our information, knowledge, and belief.

Parent \_\_\_\_\_

Date \_\_\_\_\_

Subscribed and Sworn before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

\_\_\_\_\_ Notary's Signature and Seal