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

_____

Helping Children to Bridge the Gap Between Potential and Performance

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_____
Asthma_____
Diabetes_____
Drug Sensitivities_____
Heart Disease_____
Injuries _____
Lyme's Disease_____
Mononucleosis_____
Operations_____
Otitis Media_____
Rheumatic Fever_____
Seizure Disorder_____
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