*Saddle River School District*

## *Wandell School*

*97 East Allendale Road, Saddle River, New Jersey 07458*

*School Fax (201) 236-8166* *(201) 327-0727* *Health Office fax @201)-236-2217*

*Mr. Louis J. DeLisio.*
*Interim Superintendent/ Principal*

*Mr. Glenn N. Stokes*
*Vice Principal*

2017-2018

Welcome to Wandell School! The attached forms are being sent to you for completion by you and your child's Pediatrician. A physical, vision and dental exam is required of all students entering Pre k, Kindergarten and new or transferring students into the Wandell School. Your child's immunization record is also required according to NJ State Law. Please contact the Health Office at the school if your child will be exempt from NJ immunization requirements.

The Saddle River Board of Education requires the enclosed forms be submitted before admittance to Wandell School. Please note the following requirements, in addition to the regularly scheduled immunizations;

- The Hepatitis B vaccination (a series of 3 vaccinations) requirement became effective as of January 1, 2001.
- All children entering Kindergarten need 2 doses of the MEASLES vaccine.
- Haemophilis B (Hib) is required for children in pre-school. They must have had 2 doses between ages 2-11 months. The THIRD dose is needed AFTER the first birthday.
- Please return all completed forms to the Wandell School Health Office as soon as possible.
- Your child will not be permitted to start school without the necessary forms and immunizations (Your child's Pediatrician must SIGN and STAMP the necessary forms)

Thank you so much for your attention in this very important health matter regarding the NJ state requirements for public school attendance. Please feel free to contact me if you have any questions, comments or concerns.

Very truly yours,

Patricia O'Neill RN

Patricia O'Neill RN MSN CSN

# WANDELL SCHOOL INFORMATION

STUDENT _____ CLASS OF _____

ADDRESS _____ PHONE _____

PHYSICIAN _____ DR. PHONE _____

ALLERGIES/MEDICAL CONDITIONS (may be included in medic alert list given to staff)

_____

PARENT/GUARDIAN INFORMATION (indicate any court orders/restrictions)

| | MOTHER | FATHER |
|---|---|---|
| NAME | | |
| ADDRESS | | |
| HOME PHONE | | |
| CELL PHONE | | |
| EMPLOYER | | |
| WORK PHONE | | |
| E-MAIL | | |

PRIMARY EMERGENCY CONTACTS: (authorized to pick up child in an emergency)

| | CONTACT 1 | CONTACT 2 |
|---|---|---|
| NAME | | |
| PHONE | | |
| CELL PHONE | | |
| WORK PHONE | | |

PERMISSIONS: (PLEASE CIRCLE)

YES NO My child's photo/image and name can be included in any form of media and district mailings involving school activities.

YES NO My child has health insurance _____company).

*NJ Family Care provides free or low cost health insurance for uninsured children and certain low income parents. Call 800-701-0710 or visit www.njfamilycare.org to apply online. Regarding uninsured children: You may release my name and address to NJ Family Care program to contact me about health insurance.*
*(Written consent required pursuant to 20 U.S.C. 1232g (b)(1) and 34 C.F.R. 99.30 (b).*

*Parent Signature*_____ *Printed Name*_____ *Date*_____

PLEASE NOTE THAT THE WANDELL STUDENT HANDBOOK CAN BE FOUND AT:
WWW.WANDELLSCHOOL.ORG

YES NO I will read the Acceptable Use Policy with my child.

YES NO I will review the Student Handbook with my child.

YES NO I will read the Harassment/Intimidation/Bullying Policy with my child.

**The signatures below indicate that the above information is for this academic year.**

_____

Signature of Parent/Guardian Signature of Student Date

PLEASE REPORT ANY CHANGES TO THE SCHOOL OFFICE IMMEDIATELY. 8/2014

Saddle River School District
Wandell School
97 East Allendale Road, Saddle River, NJ 07458

School (201) 327-0727 Nurse O'Neill RN MSN CSN Health Office Fax (201) 236-8166

Mr. Louis DeLisio
Interim Superintendent/Principal

Glenn N. Stokes
Vice Principal

Parent/Guardian Consent for Delegate Administration of Epinephrine Auto Injector

Dear Parent/ Guardian:

The State of New Jersey has enacted a law which allows emergency administration of epinephrine to students for anaphylaxis (P.L. 2015, c. 13). In addition to the current law, NJ has now included requirements that will allow the school nurse or trained delegate to administer epinephrine to student s who, in good faith, believes the student is having an anaphylactic reaction or any student whose parent has not:

a. provided written authorization for the administration of epinephrine (N.J.S.A. 18A:40-12.5a);
b. provided written orders from the physician or APN that the student requires epinephrine for anaphylaxis (N.J.S.A. 18A:40-12.5b);
c. received written notice from the BOE that the agencies and their employees or agents have no liability as a result of an injury arising from the administration of epinephrine (N.J.S.A. 18A:4012.5c); and
d. signed a statement releasing the BOE of liability (N.J.S.A. 18A40-12.5d).

For more information regarding the new law, please go to http://www.njleg.state.nj.us/2014/Bills/PL15/13_.HTM or send an email to schoolhealthservices@doe.state.nj.us Please feel free to contact me with any comments, questions or concerns regarding the New Epinephrine Requirements for Schools.

_____I approve having delegate(s) assigned for my child. I understand that a list of my student's delegates is available for review in the Health Office.

_____ I decline delegate administration of epinephrine for my child.

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Parent/Guardian Name (PRINTED) Signature Date

*Saddle River School District*
***Wandell School***
***97 East Allendale Road, Saddle River, New Jersey 07458***
***School Phone (201) 327-0727*** ***School Fax (201) 236-8166***
***Health Office Fax (201) 236-2217***

*Mr. Louis J. DeLisio.*
*Interim Superintendent/ Principal*

*Mr. Glenn N. Stokes*
*Vice Principal*

CONSENT FOR RELEASE OF MEDICAL INFORMATION

Dear Parents/Guardians;

With regard to the health, safety and well being of your child, please take note of the following information;

- It is sometimes necessary for the school nurse to contact your child's Pediatrician or Health Care Provider to discuss medical information.
- All of your child's medical records are kept secure, stored in a locked file cabinet and maintained in the health office, separate from their other personnel records.
- There may be situations whereby medical information may be shared with the school staff in order to provide your child with the necessary, supportive care they made need.
- In order to discuss your child's medical information, as stated in the above notations, it is necessary to keep a signed and dated medical release of information on file.
- Please read the information below then print, sign and date on the lines provided at the bottom of the page.
- Please return this form to the Wandell School Health office before the start of the new school year.

I hereby authorize and give consent to Patricia O'Neill RN MSN CSN School Nurse at Wandell Elementary School to discuss the information recorded in my child's health record as stated in the above mentioned scenarios.

_____

Child's Name (Printed) DOB Grade

_____

Name (Printed) Signature Date

5/2017

*Saddle River School District Wandell School*
*97 East Allendale Road, Saddle River, New Jersey 07458*
*Health Office 201-327-0727* *Health Office Fax (201)-236-2217*
*Mr. Louis j. DeLisio* *Mr. Glenn N. Stokes*
*Interim Superintendent/ Principal* *Vice Principal*
*Patricia O'Neill RN MSN CSN*

## **MEDICATION PERMISSION FORM INSTRUCTIONS**

In order for the school nurse to administer any medication to your child;

- **Your child's doctor must complete the form at the bottom of this page for...**
  - **Any medication** that would be required **for a limited time**, such as antibiotics, antihistamines, etc.
  - **Any over-the-counter medication** given **when needed** throughout the year, such as Tylenol, Advil, cough medicine, eye drops, etc.
  - **Any asthma medication** must returned with THIS FORM & ASTHMA ACTION PLAN
  - **All prescription medications** (Ritalin, Epipen, etc.) Must have this form completed including medications required to be given according to the FOOD ALLERGY ACTION PLAN.
  - **All medications MUST** be provided by parents in its;
    **1.) Original unopened container**
    **2.) Pharmacy label with the child's *Name *Medication *Dose *Route and *Time to be given***
    **3.) **It is recommended that 2 Epipens are provided for the school in the original unopened box****

Thank you for your cooperation with this extremely important health care need.
Very truly yours,

Patricia R. O'Neill RN MSN CSN
Wandell School Nurse

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I request the school nurse to administer the **medication** prescribed by me for the period from:

_____ to _____ for (student's name) _____

****This medication will be supplied by the parents/guardian in its **original container****.
****The medication container will have the **child's name, medication dose, route, and time(s) to be given****

Rx. _____
Sig. _____
1. Purpose of medication: _____
2. Adverse symptoms to look for: _____

Please check the appropriate box if you wish your child to receive:

- ☐ Tylenol: age-appropriate dose for fever/pain/headache
- ☐ Motrin: age-appropriate dose for fever/pain/headache

**Doctor's Signature** **Doctor's Name (Printed) or STAMP** **Date**

**Parent/Guardian Signature (Required)** **Parent/Guardian Name (Printed)** **Date**

****No medication will be given until the completed form with both Doctor and Parent/ Guardian signatures are returned****

*Where Excellence Is Our First Priority*

5/2017

*Saddle River School District Wandell School*
*Health Office 201-327-0727 x212* *Nurse O'Neill RN MSN CSN* *Health Office Fax (201)-236-2217*

**Medication # 1**...I request the school nurse to administer the **medication** prescribed by me for the period from:

_____ to _____ for (student's name) _____

**This medication will be supplied by the parents/guardian in its **original container**
**The medication container will have the **child's name, medication dose, route, and time(s) to be given**
Rx. _____
Sig. _____
1. Purpose of medication: _____
2. Adverse symptoms to look for: _____

Please check the appropriate box if you wish your child to receive:
- ☐ Tylenol: age-appropriate dose for fever/pain/headache
- ☐ Motrin: age-appropriate dose for fever/pain/headache

**Doctor's Signature** **Doctor's Name (Printed) or STAMP** **Date**

**Parent/Guardian Signature (Required)** **Parent/Guardian Name (Printed)** **Date**

**Medication #2**...I request the school nurse to administer the **medication** prescribed by me for the period from:

_____ to _____ for (student's name) _____

**This medication will be supplied by the parents/guardian in its **original container**
**The medication container will have the **child's name, medication dose, route, and time(s) to be given**

Rx. _____
Sig. _____
3. Purpose of medication: _____
4. Adverse symptoms to look for: _____

Please check the appropriate box if you wish your child to receive:
- ☐ Tylenol: age-appropriate dose for fever/pain/headache
- ☐ Motrin: age-appropriate dose for fever/pain/headache

**Doctor's Signature** **Doctor's Name (Printed) or STAMP** **Date**

**Parent/Guardian Signature (Required)** **Parent/Guardian Name (Printed)** **Date**

**Medication #3**...I request the school nurse to administer the **medication** prescribed by me for the period from:

_____ to _____ for (student's name) _____

**This medication will be supplied by the parents/guardian in its **original container**
**The medication container will have the **child's name, medication dose, route, and time(s) to be given**

Rx. _____
Sig. _____
5. Purpose of medication: _____
6. Adverse symptoms to look for: _____

Please check the appropriate box if you wish your child to receive:
- ☐ Tylenol: age-appropriate dose for fever/pain/headache
- ☐ Motrin: age-appropriate dose for fever/pain/headache

**Doctor's Signature** **Doctor's Name (Printed) or STAMP** **Date**

**Parent/Guardian Signature (Required)** **Parent/Guardian Name (Printed)** **Date**

State of New Jersey
DEPARTMENT OF EDUCATION

# HEALTH HISTORY UPDATE QUESTIONNAIRE

**Name of School** _____

**To participate on a school-sponsored interscholastic or intramural athletic team or squad, each student whose physical examination was completed more than 90 days prior to the first day of official practice shall provide a health history update questionnaire completed and signed by the student's parent or guardian.**

**Student** _____ **Age**_____ **Grade** _____

**Date of Last Physical Examination**_____ **Sport**_____

**Since the last pre-participation physical examination, has your son/daughter:**

1. Been medically advised not to participate in a sport? Yes____ No____
   If yes, describe in detail _____
2. Sustained a concussion, been unconscious or lost memory from a blow to the head? Yes____ No____
   If yes, explain in detail _____
3. Broken a bone or sprained/strained/dislocated any muscle or joints? Yes____ No____
   If yes, describe in detail _____
4. Fainted or "blacked out?" Yes____ No____
   If yes, was this during or immediately after exercise? _____
5. Experienced chest pains, shortness of breath or "racing heart?" Yes____ No____
   If yes, explain _____
6. Has there been a recent history of fatigue and unusual tiredness? Yes____ No____
7. Been hospitalized or had to go to the emergency room? Yes____ No____
   If yes, explain in detail _____
8. Since the last physical examination, has there been a sudden death in the family or has any member of the family under age 50 had a heart attack or "heart trouble?" Yes____
9. Started or stopped taking any over-the-counter or prescribed medications? Yes____ No____
   If yes, name of medication(s) _____

**Date:**_____ **Signature of parent/guardian** _____

**PLEASE RETURN COMPLETED FROM TO THE SCHOOL NURSES'S OFFICE**

# UNIVERSAL CHILD HEALTH RECORD

*Endorsed by:* *American Academy of Pediatrics, New Jersey Chapter*
*New Jersey Academy of Family Physicians*
*New Jersey Department of Health and Senior Services*

## 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<br>☐ Date Next Immunization Due: |
|---|---|

### MEDICAL CONDITIONS

| | | |
|---|---|---|
| Chronic Medical Conditions/Related Surgeries<br>• List medical conditions/ongoing surgical concerns: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Medications/Treatments<br>• List medications/treatments: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Limitations to Physical Activity<br>• List limitations/special considerations: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Special Equipment Needs<br>• List items necessary for daily activities | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Allergies/Sensitivities<br>• List allergies: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Special Diet/Vitamin & Mineral Supplements<br>• List dietary specifications: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Behavioral Issues/Mental Health Diagnosis<br>• List behavioral/mental health issues/concerns: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Emergency Plans<br>• List emergency plan that might be needed and the sign/symptoms to watch for: | ☐ None<br>☐ 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 and Senior Services, Immunization Program at 609-588-7512.
   - 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.state.nj.us/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.

Name _____ Grade ____ Teacher _____

## TO BE COMPLETED BY PHYSICIAN

A. New Students Complete information for all immunizations must be submitted.
Please indicate month, day, and year for each immunization.

Returning Students Please note date of last booster and any other immunization that has been given in the last year.

| VACCINE TYPE | DISEASE Mo/Year | Primary Series | | | Boosters | | |
|---|---|---|---|---|---|---|---|
| | | 1st Dose Mo/Day/Yr | 2nd Dose Mo/Day/Yr | 3rd Dose Mo/Day/yr | Mo/Day/Yr | Mo/Day/Yr | Mo/Day/Yr |
| DPT and/or Td | | | | | | | |
| Polio | | | | | | | |
| Measles | | | | | | | |
| Rubella | | | | | | | |
| Mumps | | | | | | | |
| Chicken Pox | | | | | | | |
| HIB | | | | | | | |
| Hepatitis B | | | | | | | |
| Other | | | | | | | |
| | | | | | | | |

B. Mantoux Tuberculin Test (not Tine and other tuberculin tests) is required for any student new to Wandell from a high TB incidence country.

| Tuberculin Tests | | |
|---|---|---|
| Date | Type/Lot No. | Reaction (mm induration) |
| | | |
| | | |
| | | |

If positive, was chest x-ray taken? Date Result
What medication, if any? Dosage

C. Lab Screening Tests

| Type | Date | Result | Date | Result |
|---|---|---|---|---|
| Hct/Hgb | | | | |
| Hct/Hgb | | | | |
| IEM | | | | |
| U/A | | | | |
| Lead Level | | | | |
| Other | | | | |

## MINIMAL IMMUNIZATION REQUIREMENTS FOR SCHOOL ATTENDANCE IN NEW JERSEY
## N.J.A.C. 8:57-4: Immunization of Pupils in School

| DISEASE(S) | MEETS IMMUNIZATION REQUIREMENTS | COMMENTS |
|---|---|---|
| **DTaP** | (AGE 1-6 YEARS): 4 doses, with one dose given on or after the 4th birthday, OR any 5 doses.<br>(AGE 7-9 YEARS): 3 doses of Td or any previously administered combination of DTP, DTaP, and DT to equal 3 doses. | Any child entering pre-school, pre-Kindergarten, or Kindergarten needs a minimum of four doses. Pupils after the seventh birthday should receive adult type Td. DTP/Hib vaccine and DTaP also valid DTP doses.<br>Laboratory evidence of immunity is also acceptable. |
| **Tdap** | GRADE 6 *(or comparable age level for special education programs)*: 1 dose | For pupils entering Grade 6 on or after 9-1-08 and born on or after 1-1-97.<br>A child does not need a Tdap dose until FIVE years after the last DTP/DTaP or Td dose. |
| **POLIO** | (AGE 1-6 YEARS): 3 doses, with one dose given on or after the 4th birthday, OR any 4 doses.<br>(AGE 7 or OLDER): Any 3 doses. | Either Inactivated Polio Vaccine (IPV) or Oral Polio Vaccine (OPV) separately or in combination is acceptable.<br>Polio vaccine is not required of pupils 18 years of age or older.<br>Laboratory evidence of immunity is also acceptable. |
| **MEASLES** | If born before 1-1-90, 1 dose of a live Measles-containing vaccine on or after the first birthday.<br>If born on or after 1-1-90, 2 doses of a live Measles-containing vaccine on or after the first birthday.<br>If entering a college or university after 9-1-95 and previously unvaccinated, 2 doses of a live Measles-containing vaccine on or after the first birthday. | Any child over 15 months of age entering child care, pre-school, or pre-Kindergarten needs a minimum of 1 dose of measles vaccine.<br>Any child entering Kindergarten needs 2 doses.<br>Previously unvaccinated students entering college after 9-1-95 need 2 doses of measles-containing vaccine or any combination containing live measles virus administered after 1968. Documentation of 2 prior doses is acceptable.<br>Laboratory evidence of immunity is also acceptable.<br>Intervals between first and second measles/MMR/MR doses cannot be less than 1 month. |
| **RUBELLA and MUMPS** | 1 dose of live Mumps-containing vaccine on or after the first birthday.<br>1 dose of live Rubella-containing vaccine on or after the first birthday. | Any child over 15 months of age entering child care, pre-school, or pre-Kindergarten needs 1 dose of rubella and mumps vaccine.<br>Any child entering Kindergarten needs 1 dose each.<br>Each student entering college for the first time after 9-1-95 needs 1 dose of rubella and mumps vaccine or any combination containing live rubella and mumps virus administered after 1968.<br>Laboratory evidence of immunity is also acceptable. |
| **VARICELLA** | 1 dose on or after the first birthday. | All children 19 months of age and older enrolled into a child care/pre-school center after 9-1-04 or children born on or after 1-1-98 entering a school for the first time in Kindergarten or Grade 1 need 1 dose of varicella vaccine.<br>Laboratory evidence of immunity, physician's statement or a parental statement of previous varicella disease is also acceptable. |
| **HAEMOPHILUS INFLUENZAE B (Hib)** | (AGE 2-11 MONTHS)[1]: 2 doses<br>(AGE 12-59 MONTHS)[2]: 1 dose | Mandated only for children enrolled in child care, pre-school, or pre-Kindergarten.<br>[1] Minimum of 2 doses of Hib vaccine is needed if between the ages of 2-11 months.<br>[2] Minimum of 1 dose of Hib vaccine is needed after the first birthday.<br>DTP/Hib and Hib/Hep B also valid Hib doses. |
| **HEPATITIS B** | (K-GRADE 12): 3 doses or 2 doses [1] | [1] If a child is between 11-15 years of age and has not received 3 prior doses of Hepatitis B then the child is eligible to receive 2-dose Hepatitis B Adolescent formulation.<br>Laboratory evidence of immunity is also acceptable. |
| **PNEUMO-COCCAL** | (AGE 2-11 MONTHS)[1]: 2 doses<br>(AGE 12-59 MONTHS)[2]: 1 dose | Mandated only for children enrolled in child care, pre-school, or pre-Kindergarten.<br>[1] Minimum of 2 doses of Pneumococcal vaccine is needed if between the ages of 2-11 months.<br>[2] Minimum of 1 dose of Pneumococcal vaccine is needed after the first birthday. |
| **MENINGO-COCCAL** | (Entering GRADE 6 *(or comparable age level for Special Ed programs)*: 1 dose [1]<br>(Entering a four-year college or University, previously unvaccinated and residing in a campus dormitory): 1 dose [2] | [1] For pupils entering Grade 6 on or after 9-1-08 and born on or after 1-1-97.<br>[2] Previously unvaccinated students entering a four-year college or university after 9-1-04 and who reside in a campus dormitory, need 1 dose of meningococcal vaccine. Documentation of one prior dose is acceptable. |
| **INFLUENZA** | (AGES 6-59 MONTHS): 1 dose ANNUALLY | For children enrolled in child care, pre-school or pre-Kindergarten on or after 9-1-08.<br>1 dose to be given between September 1 and December 31 of each year. |

### AGE APPROPRIATE VACCINATIONS (FOR LICENSED CHILD CARE CENTERS/PRE-SCHOOLS)

| CHILD'S AGE | NUMBER OF DOSES CHILD SHOULD HAVE (BY AGE): |
|---|---|
| 2-3 Months | 1 dose DTaP, 1 dose Polio, 1 dose Hib, 1 dose PCV7 |
| 4-5 Months | 2 doses DTaP, 2 doses Polio, 2 doses Hib, 2 doses PCV7 |
| 6-7 Months | 3 doses DTaP, 2 doses Polio, 2-3 doses Hib, 2-3 doses PCV7, 1 dose Influenza |
| 8-11 Months | 3 doses DTaP, 2 doses Polio, 2-3 doses Hib, 2-3 doses PCV7, 1 dose Influenza |
| 12-14 Months | 3 doses DTaP, 2 doses Polio, 1 dose Hib, 2-3 doses PCV7, 1 dose Influenza |
| 15-17 Months | 3 doses DTaP, 2 doses Polio, 1 dose MMR, 1 dose Hib, 1 dose PCV7, 1 dose Influenza |
| 18 Months-4 Years | 4 doses DTaP, 3 doses Polio, 1 dose MMR, 1 dose Hib, 1 dose Varicella, 1 dose PCV7, 1 dose Influenza |

### PROVISIONAL ADMISSION:

Provisional admission allows a child to enter/attend school but must have a minimum of one dose of each of the required vaccines. Pupils must be actively in the process of completing the series. If a pupil is <5 years of age, they have 17 months to complete the immunization requirements. If a pupil is 5 years of age and older, they have 12 months to complete the immunization requirements.

### GRACE PERIODS:

- 4-day grace period: All vaccines doses administered less than or equal to four days before either the specified minimum age or dose spacing interval shall be counted as valid and shall not require revaccination in order to enter or remain in a school, pre-school or child care facility.
- 30-day grace period: Those children transferring into a New Jersey school, pre-school, or child care center from out of state/out of country may be allowed a 30-day grace period in order to obtain past immunization documentation before provisional status shall begin.

WANDELL SCHOOL

Tele: (201) 327-0727 97 East Allendale Road Fax: (201) 236-8166
Saddle River, New Jersey 07458

# Dental Examination Record

Child's Name _____

Number of Cavities _____

Number Treated _____

Gums _____

Recommendations _____

_____

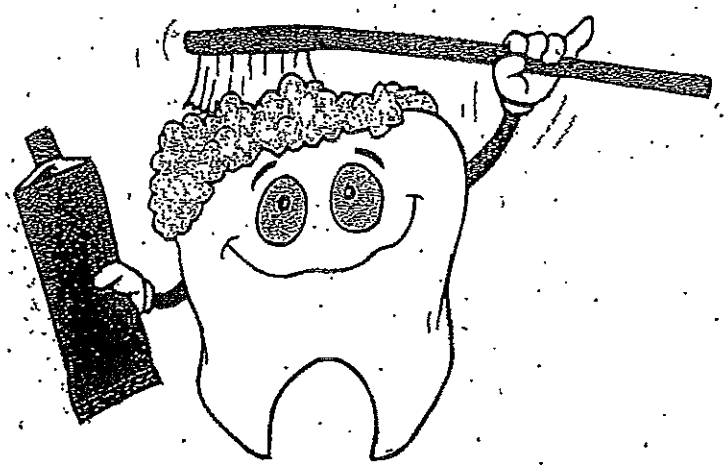
Date of Examination _____

Doctor's Name _____

Address _____

Telephone Number _____ Fax Number _____

Doctor's Signature _____



WANDELL SCHOOL

Tele: (201) 327-0727 97 East Allendale Road Fax: (201) 236-8166
Saddle River, New Jersey 07458

# Vision Examination Record

Child's Name _____

| | | Distance | Near | | Distance | Near |
|---|---|---|---|---|---|---|
| Vision without correction | O.D. | _____ | _____ | O.S. | _____ | _____ |
| Vision with correction | O.D. | _____ | _____ | O.S. | _____ | _____ |

Muscle Balance _____

Binocular Vision Near _____

Far _____

Fusion Depth _____

Eye Disease or Defect _____

DIAGNOSIS: _____

_____

Recommendations _____

_____

Should wear glasses? _____ When? _____

Re-examination _____ Date? _____

Other _____

Date of Examination _____

Doctor's Name _____

Address _____

Telephone Number _____

Fax Number _____

Saddle River School District
Wandell Elementary School
97 E. Allendale Rd.
Saddle River, NJ 07458

- PLEASE READ THE NJDOE FACT SHEETS
- SIGN OFF BELOW
- RETURN SIGNED FORMS TO THE SCHOOL HEALTH OFFICE

Sports related Concussion and Head Injury Fact Sheet and Parent/Guardian Acknowledgement Form

I/We acknowledge that we read and reviewed the Sports and Concussion and Head Injury Fact Sheet.

Student Signature_____

Parent/Guardian Signature_____

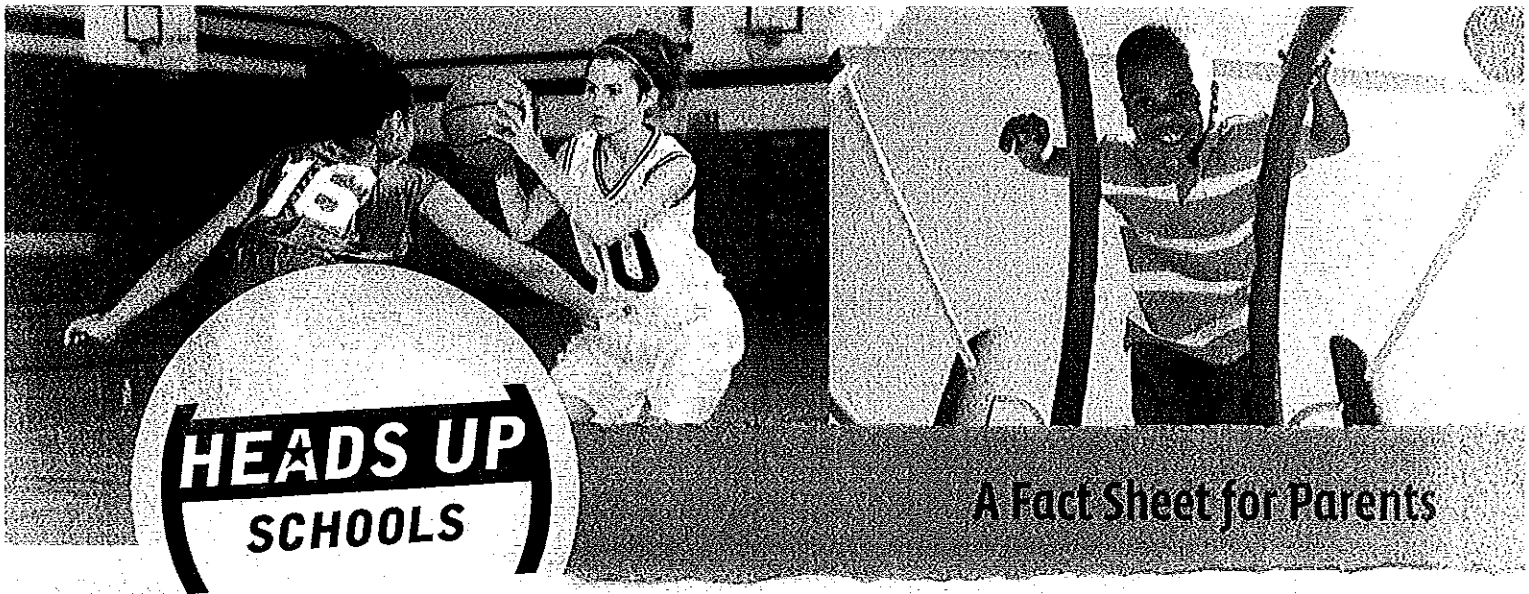
Date_____

Sports-Related Eye Injuries Educational Fact Sheet For Parents

I/We acknowledge that we have read and reviewed the Sports-Related Eye Injuries Educational Fact Sheet.

Student Signature:_____
Parent/Guardian Signature_____

Date_____



# HEADS UP SCHOOLS

## A Fact Sheet for Parents

## What is a concussion?

A concussion is a type of brain injury that changes the way the brain normally works. A concussion is caused by a bump, blow, or jolt to the head. Concussions can also occur from a blow to the body that causes the head and brain to move rapidly back and forth. Even what seems to be a mild bump to the head can be serious.

Concussions can have a more serious effect on a young, developing brain and need to be addressed correctly.

## What are the signs and symptoms of a concussion?

You can't see a concussion. Signs and symptoms of concussion can show up right after an injury or may not appear or be noticed until hours or days after the injury. It is important to watch for changes in how your child or teen is acting or feeling, if symptoms are getting worse, or if s/he just "doesn't feel right." Most concussions occur without loss of consciousness.

If your child or teen reports *one or more* of the symptoms of concussion listed below, or if you notice the symptoms yourself, seek medical attention right away. Children and teens are among those at greatest risk for concussion.

### SIGNS AND SYMPTOMS OF A CONCUSSION

**SIGNS OBSERVED BY PARENTS OR GUARDIANS**

- Appears dazed or stunned
- Is confused about events
- Answers questions slowly
- Repeats questions
- Can't recall events *prior* to the hit, bump, or fall
- Can't recall events *after* the hit, bump, or fall
- Loses consciousness (even briefly)
- Shows behavior or personality changes
- Forgets class schedule or assignments

**SYMPTOMS REPORTED BY YOUR CHILD OR TEEN**

**Thinking/Remembering:**

- Difficulty thinking clearly
- Difficulty concentrating or remembering
- Feeling more slowed down
- Feeling sluggish, hazy, foggy, or groggy

**Physical:**

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Fatigue or feeling tired
- Blurry or double vision
- Sensitivity to light or noise
- Numbness or tingling
- Does not "feel right"

**Emotional:**

- Irritable
- Sad
- More emotional than usual
- Nervous

**Sleep*:**

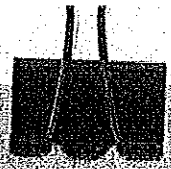
- Drowsy
- Sleeps *less* than usual
- Sleeps *more* than usual
- Has trouble falling asleep

**Only ask about sleep symptoms if the injury occurred on a prior day.*

To download this fact sheet in Spanish, please visit: www.cdc.gov/Concussion. Para obtener una copia electrónica de esta hoja de información en español, por favor visite: www.cdc.gov/Concussion.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

May 2010



## DANGER SIGNS

**Be alert for symptoms that worsen over time. Your child or teen should be seen in an emergency department right away if s/he has:**

- **One pupil (the black part in the middle of the eye) larger than the other**
- **Drowsiness or cannot be awakened**
- **A headache that gets worse and does not go away**
- **Weakness, numbness, or decreased coordination**
- **Repeated vomiting or nausea**
- **Slurred speech**
- **Convulsions or seizures**
- **Difficulty recognizing people or places**
- **Increasing confusion, restlessness, or agitation**
- **Unusual behavior**
- **Loss of consciousness (even a brief loss of consciousness should be taken seriously)**

**Children and teens with a concussion should NEVER return to sports or recreation activities on the same day the injury occurred. They should delay returning to their activities until a health care professional experienced in evaluating for concussion says they are symptom-free and it's OK to return to play. This means, until permitted, not returning to:**

- **Physical Education (PE) class,**
- **Sports practices or games, or**
- **Physical activity at recess.**

## What should I do if my child or teen has a concussion?

1. **Seek medical attention right away.** A health care professional experienced in evaluating for concussion can determine how serious the concussion is and when it is safe for your child or teen to return to normal activities, including physical activity and school (concentration and learning activities).
2. **Help them take time to get better.** If your child or teen has a concussion, her or his brain needs time to heal. Your child or teen may need to limit activities while s/he is recovering from a concussion. Exercising or activities that involve a lot of concentration, such as studying, working on the computer, or playing video games may cause concussion symptoms (such as headache or tiredness) to reappear or get worse. After a concussion, physical and cognitive activities—such as concentration and learning—should be carefully managed and monitored by a health care professional.
3. **Together with your child or teen, learn more about concussions.** Talk about the potential long-term effects of concussion and the dangers of returning too soon to normal activities (especially physical activity and learning/concentration). For more information about concussion and free resources, visit: www.cdc.gov/Concussion.

## How can I help my child return to school safely after a concussion?

Help your child or teen get needed support when returning to school after a concussion. Talk with your child's teachers, school nurse, coach, speech-language pathologist, or counselor about your child's concussion and symptoms. Your child may feel frustrated, sad, and even angry because s/he cannot return to recreation and sports right away, or cannot keep up with schoolwork. Your child may also feel isolated from peers and social networks. Talk often with your child about these issues and offer your support and encouragement. As your child's symptoms decrease, the extra help or support can be removed gradually. Children and teens who return to school after a concussion may need to:

- Take rest breaks as needed,
- Spend fewer hours at school,
- Be given more time to take tests or complete assignments,
- Receive help with schoolwork, and/or
- Reduce time spent reading, writing, or on the computer.

*To learn more about concussion and to order materials FREE OF CHARGE, go to: www.cdc.gov/Concussion or call 1.800.CDC.INFO.

# SPORTS-RELATED EYE INJURIES:

## AN EDUCATIONAL FACT SHEET FOR PARENTS

Participating in sports and recreational activities is an important part of a healthy, physically active lifestyle for children. Unfortunately, injuries can, and do, occur. Children are at particular risk for sustaining a sports-related eye injury and most of these injuries can be prevented. Every year, more than 30,000 children sustain serious sports-related eye injuries. Every 13 minutes, an emergency room in the United States treats a sports-related eye injury.[1] According to the National Eye Institute, the sports with the highest rate of eye injuries are: baseball/softball, ice hockey, racquet sports, and basketball, followed by fencing, lacrosse, paintball and boxing.

Thankfully, there are steps that parents can take to ensure their children's safety on the field, the court, or wherever they play or participate in sports and recreational activities.

## Prevention of Sports-Related Eye Injuries

Approximately 90% of sports-related eye injuries can be prevented with simple precautions, such as using protective eyewear.[2] **Each sport has a certain type of recommended protective eyewear, as determined by the American Society for Testing and Materials (ASTM). Protective eyewear should sit comfortably on the face. Poorly fitted equipment may be uncomfortable, and may not offer the best eye protection. Protective eyewear for sports includes, among other things, safety goggles and eye guards, and it should be made of polycarbonate lenses, a strong, shatterproof plastic. Polycarbonate lenses are much stronger than regular lenses.**[3]

Health care providers (HCP), including family physicians, ophthalmologists, optometrists, and others, play a critical role in advising students, parents and guardians about the proper use of protective eyewear. To find out what kind of eye protection is recommended, and permitted for your child's sport, visit the National Eye Institute at http://www.nei.nih.gov/sports/findingprotection.asp. Prevent Blindness America also offers tips for choosing and buying protective eyewear at http://www.preventblindness.org/tips-buying-sports-eye-protectors,and http://www.preventblindness.org/ recommended-sports-eye-protectors.

It is recommended that all children participating in school sports or recreational sports wear protective eyewear. Parents and coaches need to make sure young athletes protect their eyes, and properly gear up for the game. Protective eyewear should be part of any uniform to help reduce the occurrence of sports-related eye injuries. Since many youth teams do not require eye protection, parents may need to ensure that their children wear safety glasses or goggles whenever they play sports. Parents can set a good example by wearing protective eyewear when they play sports.

[1] National Eye Institute, National Eye Health Education Program, Sports-Related Eye Injuries: What You Need to Know and Tips for Prevention, www.nei.nih.gov/sports/pdf/sportsrelatedeyeInjuries.pdf, December 26, 2013.

[2] Rodriguez, Jorge O., D.O., and Lavina, Adrian M., M.D., Prevention and Treatment of Common Eye Injuries in Sports, http://www.aafp.org/afp/2003/0401/p1481.html, September 4, 2014; National Eye Health Education Program, Sports-Related Eye Injuries: What You Need to Know and Tips for Prevention, www.nei.nih.gov/sports/pdf/sportsrelatedeyeInjuries.pdf, December 26, 2013.

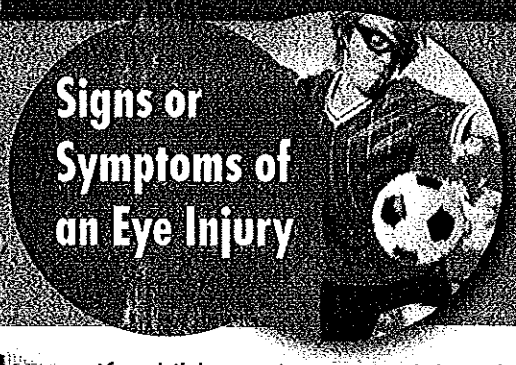
[3] Bedinghaus, Troy, O.D., Sports Eye Injuries, http://vision.about.com/od/emergencyeyecare/a/Sports_Injuries.htm, December 27, 2013.

## Most Common Types of Eye Injuries

The most common types of eye injuries that can result from sports injuries are blunt injuries, corneal abrasions and penetrating injuries.

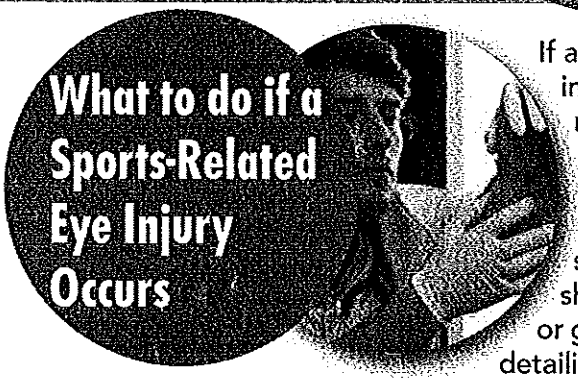
- **Blunt injuries:** Blunt injuries occur when the eye is suddenly compressed by impact from an object. Blunt injuries, often caused by tennis balls, racquets, fists or elbows, sometimes cause a black eye or hyphema, (bleeding in front of the eye). More serious blunt injuries often break bones near the eye, and may sometimes seriously damage important eye structures and/or lead to vision loss.
- **Corneal abrasions:** Corneal abrasions are painful scrapes on the outside of the eye, or the cornea. Most corneal abrasions eventually heal on their own, but a doctor can best assess the extent of the abrasion, and may prescribe medication to help control the pain. The most common cause of a sports-related corneal abrasion is being poked in the eye by a finger.
- **Penetrating injuries:** Penetrating injuries are caused by a foreign object piercing the eye. Penetrating injuries are very serious, and often result in severe damage to the eye. These injuries often occur when eyeglasses break while they are being worn. Penetrating injuries must be treated quickly in order to preserve vision.[4]

## Signs or Symptoms of an Eye Injury



- Pain when looking up and/or down, or difficulty seeing;
- Tenderness;
- Sunken eye;
- Double vision;
- Severe eyelid and facial swelling;
- Difficulty tracking;
- The eye has an unusual pupil size or shape;
- Blood in the clear part of the eye;
- Numbness of the upper cheek and gum; and/or
- Severe redness around the white part of the eye.

## What to do if a Sports-Related Eye Injury Occurs



If a child sustains an eye injury, it is recommended that he/she receive immediate treatment from a licensed HCP (e.g., eye doctor) to reduce the risk of serious damage, including blindness. It is also recommended that the child, along with his/her parent or guardian, seek guidance from the HCP regarding the appropriate amount of time to wait before returning to sports competition or practice after sustaining an eye injury. The school nurse and the child's teachers should also be notified when a child sustains an eye injury. A parent or guardian should also provide the school nurse with a physician's note detailing the nature of the eye injury, any diagnosis, medical orders for the return to school, as well as any prescription(s) and/or treatment(s) necessary to promote healing, and the safe resumption of normal activities, including sports and recreational activities.

## Return to Play and Sports

According to the American Family Physician Journal, there are several guidelines that should be followed when students return to play after sustaining an eye injury. For example, students who have sustained significant ocular injury should receive a full examination and clearance by an ophthalmologist or optometrist. In addition, students should not return to play until the period of time recommended by their HCP has elapsed. For more minor eye injuries, the athletic trainer may determine that it is safe for a student to resume play based on the nature of the injury, and how the student feels. No matter what degree of eye injury is sustained, it is recommended that students wear protective eyewear when returning to play and immediately report any concerns with their vision to their coach and/or the athletic trainer.

***Additional information on eye safety can be found at http://isee.nei.nih.gov and http://www.nei.nih.gov/sports.***

[4]Bedinghaus, Troy, O.D., Sports Eye Injuries, http://vision.about.com/od/emergencyeyecare/a/Sports_Injuries.htm, December 27, 2013.