LACEY TOWNSHIP MIDDLE SCHOOL

A Tradition Of Pride · A Tradition Of Excellence

GREGORY BRANDIS
PRINCIPAL

Welcome to Lacey Township Middle School

Educating Students in Grades 7 – 8

- **All new students** must pre-register on the Lacey Township School District website prior to making an in-person registration appointment in Lacey Township Middle School.
- Pre-registration is located on our website at www.laceyschools.org
- Once the on-line registration is completed, contact the Lacey Township Middle School Main Office located at 660 Denton Ave (609) 242-2100.
- Please bring all required documents and completed forms to your in-person registration appointment.
- School hours are as follows: 7:30 am – 2:00 pm

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REGISTRATION DAY CHECKLIST

Please bring these items with you to your registration appointment. Students are not considered fully registered until all items are submitted.

(√) Check off each item

A	Original Birth Certificate with the raised seal. A copy will be made at your registration appointment.	
B	Four (4) forms of Proof of Residency to include any of the following items: Property tax bill, deed, contract of sale, lease agreement, mortgage voter registration, vehicle registration, license, permit, bank statements, utility bill, credit card bills, phone bill, and cancelled checks with your current Lacey address at the time of your registration meeting.	
C	Must bring appropriate completed Residency Form. This form is available on the Online Pre-Registration Page – Step 5: Residency Forms.	
D	Student Release of Records (completed by parent).	
E	Pre-Participation Physical Evaluation History Form – Physical and Immunizations (completed by Physician; submit along with current immunizations records) *See Required Medical Documents Letter.	
F	Student Medical Concerns Form & Medication Procedure Form (completed by parent, if applicable).	
G	Guardianship/Custody papers if applicable	
H	Application for Free and Reduced Price School Meals (if applicable) This is available on LTSD Website – Department & Programs ~ Food Service (Print, Fill out and Bring to Childs School)	
*	Transfer Card/Release Paperwork from previous school	
*	Service Copies; IEP, 504 for placement purposes	

*For students transferring from a school outside of Lacey Township School district.

Please make every effort to have your paperwork completed for your scheduled appointment time.

LACEY TOWNSHIP SCHOOL DISTRICT
OFFICE OF SPECIAL SERVICES
A Tradition Of Pride · A Tradition Of Excellence

JOSEPH R. BOND
DIRECTOR OF SPECIAL SERVICES

Required Medical Documents

In accordance to NJ State laws, the Lacey Township Board of Education requires that all registrants submit a completed physical examination form and an immunization record before the start of the school year. The physical form must be dated within 365 days from the start of the school year.

Universal Child Health Record Form

1. Physical Examination – completed by physician
   - A current physical should be submitted upon registration
   - If physical was not performed within 365 days from the start of the school year, a new one must be submitted immediately upon completion.
2. Immunization Form – completed by physician
   - A current immunization record must be submitted at registration, regardless of physical exam date.
   - Any subsequent immunization data should also be submitted immediately upon completion

73 Haines Street · Lanoka Harbor, NJ 08734 · Phone: (609) 971-2000 X1021 · Fax: (609) 971-5714
www.laceyschools.org

LACEY TOWNSHIP MIDDLE SCHOOL

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GREGORY BRANDIS
PRINCIPAL

Welcome to Lacey Township Middle School

Request for Student Records

Dear School Administrator:

The following student has been registered in school as of: _____

STUDENT NAME: _____ GRADE: _____

Please forward the following information to us as soon as possible so that we may properly place this student in our school:

Scholastic Records	Transfer Cards
Health Records	Birth Certificate
Test Results	Basic Skills Records
Report Cards	Discipline Records
Grade in Progress	Special Education Records
NJ SMART ID #	Attendance Record
IEP	504

Thank you for your prompt attention to this matter:

I hereby authorize the release of all available information and reports to:

Lacey Township Middle School
660 Denton Ave.
Forked River, NJ 08731

Parent's Name: _____
(please print)

Parent's Signature: _____ Date: _____

LACEY TOWNSHIP MIDDLE SCHOOL

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GREGORY BRANDIS
PRINCIPAL

Physical Examination Form

☐ Will receive a medical examination from home (family Physician)

☐ Do not have a home (family Physician), will require a medical examination from the school physician

Parent's Signature: _____ Date: _____

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LACEY TOWNSHIP SCHOOL DISTRICT
OFFICE OF SPECIAL SERVICES
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JOSEPH R. BOND
DIRECTOR OF SPECIAL SERVICES

Prescribed and/or Over the Counter Medication Procedure

(Including Aspirin, Tylenol, and Ibuprofen)

For any medication your child will take in the school, please observe the following procedure:

1. Prior to any medication being administered by the school nurse, a written document must be received. Physician's document must state:
    a. the diagnosis
    b. name of medication
    c. dosage, frequency, and time medication is to be administered
    d. physician's documentation can be faxed to the school nurse
2. Parental permission for nurse to administer the medication as directed by the physician
3. Medication prescribed 3 times a day should be taken before school, after school, and at bedtime.
4. All medication must be brought to the school nurse in the original pharmaceutical container with the student's name on it.
5. Medications must be stored in a locked cabinet with the nurse's office; students are not to carry medications on their person or keep them in their lockers.

Please notify the school nurse of any existing medical problems. Thank you for your cooperation in this matter.

Authorization for school nurse to administer medications

School _____ School Nurse _____

Student's Name _____ Date _____

Diagnosis _____ Grade _____

Medication _____ Dosage _____

Parent Signature _____ Time _____

Physician Signature _____ Stamp _____

Action to be taken when no licensed individual is available to administer medication: Hold? _____
Asthma inhalers & Epipens ONLY – Can student self-administer and carry medication? _____

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LACEY TOWNSHIP SCHOOL DISTRICT
OFFICE OF SPECIAL SERVICES
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JOSEPH R. BOND
DIRECTOR OF SPECIAL SERVICES

Student Medical Concerns Form

Parent to complete this section:

Student's Full Name _____ School Year _____

Date of Birth _____ Grade _____ School Attending _____

Physician's Name _____

Address _____

_____

Phone _____

My child has the following medical concerns that I wish to make the school nurse aware of:

_____

_____

_____

_____

If your child requires medication to be administered during school hours:

1. Complete the appropriate **Medical Authorization Form** listed on the District website.
2. Provide medication in its **original container**.
3. Prescription medications must have a **pharmacy label**.
4. A parent **must bring medication in person** to the nurse's office. Students are not permitted to carry as per school policy.
5. For students that are permitted by their physician to self-administer their medication, please complete the **Medication Self-Administration Form**.

Signature of Parent _____ Date _____

Return this form directly to the nurse at your child's school

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www.laceyschools.org

LACEY TOWNSHIP MIDDLE SCHOOL

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GREGORY BRANDIS
PRINCIPAL

September, 2022

Dear Parent:

I want to take this opportunity to thank you for your interest in the Lacey Township Middle School Voluntary Drug and Alcohol Testing Program. We believe this program will offer families another tool to identify members of our school community who are in need of help and provide your child with just one more reason to say "no" to drugs and alcohol. We are pleased to announce that the random drug and alcohol testing will begin this month and will continue throughout the school year.

The testing procedure will take place as follows:

1. The testing contractor will randomly select students to be tested.
2. The selected names will be sent to me so I can verify that a permission slip is on file for those students.
3. On the day of testing, a counselor will select the students individually to a testing area in the nurse's office, which will be closed during the testing.
4. A Certified Collection Agent from the testing contractor will oversee the collection of the sample from the student. The student will be given a paper receipt and will return to class.
5. The results of the test will be forwarded to me. In the case of a positive result, you will be contacted by a certified medical review officer to discuss the test results. If necessary, you will receive a follow-up call from me.

Once again, thank you for your participation in this program. If you have received this letter in error and do not want your child to participate in the program or have any other questions or concerns, please feel free to contact me.

Sincerely,
Gregory Brandis, Principal

LACEY TOWNSHIP MIDDLE SCHOOL

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GREGORY BRANDIS
PRINCIPAL

Consent to Participate
Lacey Township Middle School Voluntary
Random Testing for Student Alcohol or Other Drug Use Program

Student Name (Please Print): _____ Grade: _____

We hereby consent to permit the above named student to participate in the Middle School Voluntary Random Testing for Student Alcohol or Other Drug Use Program as approved by the Lacey Township School District. In issuing consent, we permit the student named above to undergo random urinalysis testing for the presence of alcohol or other drugs as outlined in district policy.

We understand that a qualified vendor will oversee the collection process.

We understand that any urine samples will be sent only to a certified laboratory for testing and that the samples will be coded to provide confidentiality.

We hereby give consent to the vendor selected by the Lacey Township School District to perform urinalysis testing for the presence of alcohol or other drugs as named in District policy.

We further give permission to the vendor selected by the Lacey Township School District to release all results of these tests to the Medical Review Officer working for the vendor. We understand these results will be forwarded to the Building Principal and will also be made available to us.

We understand that this consent agreement will be in effect for a period of twelve months from the date tested below.

We understand that the urinalysis conducted will include the following substances and be based on the following levels.

Substance	**Screen/Initial Level**	**Confirmation Level**
AMPHETAMINES (CLASS)	500 ng/ml	250 ng/ml
ECSTASY SCREEN	500 ng/ml	250 ng/ml
COCAINE METABOLITES	150 ng/ml	100 ng/ml
MARIJUANA METABOLITE	20 ng/ml	15 ng/ml
OPIATES	300 ng/ml	300 ng/ml
PCP	25 ng/ml	25 ng/ml
BARBITURATES	300 ng/ml	300 ng/ml
BENZODIAZEPINES	300 ng/ml	300 ng/ml
METHADONE	300 ng/ml	300 ng/ml
PROPOXYPHENE	300 ng/ml	300 ng/ml
OXYCODONBOXYMORPHONE	100 ng/ml	100 ng/ml
ALCOHOL, URINE	0.02 ng/ml	0.02 ng/ml

Student Signature: _____ Date: _____

Parent Signature: _____ Date: _____

LACEY TOWNSHIP SCHOOL DISTRICT
A Tradition Of Pride · A Tradition Of Excellence

VANESSA P. CLARK, PH.D.
SUPERINTENDENT OF SCHOOLS

Dear Parents:

We are pleased to offer the students of the Lacey Township School District access to the District's electronic network and technology resources. This includes access to the internet, computer equipment, and related equipment for educational purposes that will assist in preparing students for success in life and work in the 21st Century. Technology enables students to discover a variety of libraries, databases, websites, and interactive communication systems. In our classrooms of today, technology supports and strengthens teaching and learning, promotes collaboration and creativity, and provides tools to assist students with research and connect with information sources not possible otherwise. Use of the Lacey Township School District's technology resources requires that all students sign and return the Acceptable Use Policy Student Agreement.

Use of the Lacey Township School District's technology resources over the District's networks should not be considered private. The district maintains filtering software designed to block access to certain internet sites; however, the District cannot guarantee that this filtering software will, in all instances, successfully block access to materials deemed harmful, indecent, offensive, or otherwise inappropriate. The use of filtering software, as explained in the Acceptable Use of Computer Network/Computers and Resources Policy 2361, does not negate or otherwise affect the obligations of users to abide by the terms of this policy and to refrain from accessing such materials. Ultimately, parents and guardians are responsible for setting and conveying the standards that their children should follow when using media and information resources.

We recognize that this is a very busy part of the school year and thank you for taking the time to review this important information. Your support in the area of technology makes it possible to give your child the best opportunities for learning in the 21st Century.

Sincerely,

Jason England
Supervisor of Information Technology

200 Western Boulevard · Lanoka Harbor, NJ 08734 · Phone: (609) 971-2000
www.laceyschools.org

LACEY TOWNSHIP SCHOOL DISTRICT
ACCEPTABLE USE POLICY (AUP) STUDENT AGREEMENT

As a student user of Lacey Township School District's technology resources, I agree to the following rules and provisions. Please refer to District Policy and Regulation #2361 for further information.

As a student, I will:

1. only use the computer account provided to them by the district and will take the responsibility to protect their account from unauthorized access. Students will not give their personal password to anyone and will take steps to prevent others from learning their password. Students who become aware of attempts to violate or bypass security mechanisms will promptly report such attempts to their teacher or building administrator;

2. respect the privacy of information stored and accessed through Lacey Township School District's technology resources. Students will not acquire or modify, in any way, information that belongs to another person, nor will they attempt to access restricted portions of the technology infrastructure;

3. only use the software to which express rights have been granted by the school administration;

4. not copy unauthorized software onto the available data storage devices;

5. agree not to copy, disclose, modify, or transfer any materials that they did not create without the express consent of the original owner or copyright holder. Students agree not to use Lacey Township School District's technology resources to violate the terms of any software license agreement, or any applicable local, state, or federal laws;

6. agree not to use Lacey Township School District's technology resources for any purpose other than that for which they were intended;

7. not use district technology resources for personal use, personal gain, harassment, or cyberbullying;

8. use good judgment to access only information having sound educational value. Students understand that accessing illegal or inappropriate materials may result in disciplinary action;

9. understand that any violation of any provision of this agreement may result in disciplinary and/or legal action as outlined in district Policy and Regulation 2361 and 2531;

10. understand that this Acceptable Use Policy (AUP) Student Agreement remains in force as long as the student makes use of any of the available Lacey Township School District technology resources, to include, but not be limited to devices and network access, either in school or at home.

LACEY TOWNSHIP SCHOOL DISTRICT
ACCEPTABLE USE POLICY (AUP) STUDENT AGREEMENT

Please sign and return this page to your child's school

Student Section

Student Name: _____ Grade: _____

I have read the Lacey Township School District Acceptable Use Policy Student Agreement. I agree to follow the rules contained in this policy and I understand that if I violate the rules my access can be terminated and I may face disciplinary measures.

Student Signature:_____ Date:_____

Parent Section

Parent Name: _____

I have read the Lacey Township School District Acceptable Use Policy Student Agreement. I give permission for my child to access all components of the district electronic network that includes access to the internet, computer equipment, and related equipment.

Parent Signature: _____ Date: _____

ATTENTION PARENT/GUARDIAN: The preparticipation physical examination (page 3) must be completed by a health care provider who has completed the Student-Athlete Cardiac Assessment Professional Development Module.

Preparticipation Physical Evaluation
HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep a copy of this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

_____

_____

_____

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

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HE0503 9-2681/0410

New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

PREPARTICIPATION PHYSICAL EVALUATION

THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

1. Type of disability
2. Date of disability
3. Classification (if available)
4. Cause of disability (birth, disease, accident/trauma, other)
5. List the sports you are interested in playing

	Yes	No
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

_____

_____

_____

_____

_____

Please indicate if you have ever had any of the following.

	Yes	No
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers here

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

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NOTE: The preparticiaption physical examination must be conducted by a health care provider who 1) is a licensed physician, advanced practice nurse, or physician assistant; and 2) completed the Student-Athlete Cardiac Assessment Professional Development Module.

PREPARTICIPATION PHYSICAL EVALUATION
PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

1. **Consider additional questions on more sensitive issues**
   - **Do you feel stressed out or under a lot of pressure?**
   - **Do you ever feel sad, hopeless, depressed, or anxious?**
   - **Do you feel safe at your home or residence?**
   - **Have you ever tried cigarettes, chewing tobacco, snuff, or dip?**
   - **During the past 30 days, did you use chewing tobacco, snuff, or dip?**
   - **Do you drink alcohol or use any other drugs?**
   - **Have you ever taken anabolic steroids or used any other performance supplement?**
   - **Have you ever taken any supplements to help you gain or lose weight or improve your performance?**
   - **Do you wear a seat belt, use a helmet, and use condoms?**
2. **Consider reviewing questions on cardiovascular symptoms (questions 5–14).**

EXAMINATION		
Height Weight ☐ Male ☐ Female		
BP / (/) Pulse Vision R 20/ L 20/ Corrected ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart [a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic [c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason _____

Recommendations _____

_____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) (print/type)_____ Date of exam _____

Address _____ Phone _____

Signature of physician, APN, PA _____

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PREPARTICIPATION PHYSICAL EVALUATION
CLEARANCE FORM

Name _____ Sex ☐ M ☐ F Age _____ Date of birth _____

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

  Reason _____

Recommendations _____

_____

_____

_____

_____

_____

EMERGENCY INFORMATION

Allergies _____

_____

_____

_____

_____

_____

Other information _____

_____

_____

_____

_____

HCP OFFICE STAMP

SCHOOL PHYSICIAN:

Reviewed on _____
(Date)

Approved _____ Not Approved _____

Signature:_____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) _____ Date _____

Address _____ Phone _____

Signature of physician APN, PA _____

Completed Cardiac Assessment Professional Development Module

Date_____ Signature_____

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APPENDIX H

UNIVERSAL CHILD HEALTH RECORD

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

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 ☐ Date Next Immunization Due: _____

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐ None ☐ Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	☐ None ☐ Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☐ None ☐ Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐ None ☐ Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☐ None ☐ Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☐ None ☐ Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☐ None ☐ 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, Vaccine Preventable Diseases Program at 609-826-4860. 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.nj.gov/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.