NEW JERSEY ACADEMY OF TECHNOLOGY EMERGENCY CONTACT FORM

PLEASE PRINT ALL INFORMATION CLEARLY

Today's Date: _____

STUDENT INFORMATION:

_____ _____ _____
FIRST NAME MIDDLE NAME LAST NAME

Date of Birth: _____ Student Email: _____ _____ Student Phone: _____

When you live with a guardian, please provide the guardian's information.

Parent's/Guardian's Full Name:		
U.S. Home Address: Street		
City	State	Zip Code
U.S. Home Telephone # :		
Guardian e-mail address :	Guardian cell phone # :	

IN CASE OF AN EMERGENCY CONTACT:

1. Name	Relationship	
Street Address		
City	State	Zip Code
Daytime Phone #	Cellular Phone #	
Email Address		

2. Name	Relationship	
Street Address		
City	State	Zip Code
Daytime Phone #	Cellular Phone #	
Email Address		

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

Allergies: _____

Medication(s) being taken: _____

Physical impairment: _____

TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be called:

Physician's Name: _____

Address: _____

Telephone #: _____

Dentist's Name: _____

Address: _____

Telephone #: _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctors, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinin9ons of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

_____ _____

Signature of Parent/Guardian Date

PARENTS' INFORMATION:

Mother's Full Name:
Home Address:
Home Telephone # ( )
Cellular Phone # ( )
Email Address:

Father's Full Name:
Home Address:
Home Telephone # ( )
Cellular Phone # ( )
Email Address:

New Jersey Academy of Technology
353 E. Clinton Ave., Tenafly, NJ 07670
P. 201-627-8383 / F. 201-627-8384 / www.njat.us

General Permission Slip Form

I, _____ grant permission for my child _____, to participate in any field trips with NJAT. This includes, but is not limited to walks, riding in a vehicle operated by NJAT staff or parent or guardian volunteers, hikes and bike rides around the area. I understand that I will be notified in advance when a field trip is planned away from the center. I understand that every precaution will be made to keep the children safe at all times. However, if an accident does happen, I will assume all responsibility medically and financially. The staff will take all necessary measures as outlined in the parent handbook in the case of an accident or emergency. Staff with current CPR/First Aid including pediatric, will be present on all outings. Fully stocked first aid kits are present in all vehicles that transport children.

Parent/Guardian Signature _____ Date _____

Photo/Video Permission

Child's Name _____

By signing this permission form, you are acknowledging that while your child is in our facility, on field trips, or participating in NJAT sponsored activities, they may be photographed and/or videotaped. Photos and videos may be taken by staff, parent or guardian volunteers and others that are present during the activity. Pictures are used for classroom display, portfolios, parent programs, and occasional advertisement. NJAT has a Facebook page and website as well. If you do not wish your child to be posted on the web or in any other of the above mentioned ways please indicate and initial this form.

Check one below:

( ) **Yes**, I give my permission for staff and/or parents or guardians of NJAT to photograph and/or video my child during school events and daily activities.

( ) **No**, I do not want my child in any photos or videos while at NJAT

Parent/Guardian Signature _____ Date _____

Print parent/guardian Name _____

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NJAT Internet Use Policy

We believe that the Internet offers vast, diverse, and unique resources to both students and teachers. Our goal in providing Internet access is to promote educational excellence by facilitating resource sharing, innovation, and communication.

The smooth operation of the network relies upon the proper conduct of the users, who must adhere to strict guidelines. These guidelines are provided here so that students are aware of their responsibilities. In general, this requires efficient, ethical, and legal utilization of the network resources.

Students will have access to the Internet/World Wide Web resources at school. Internet use is only allowed with permission of the supervising teacher, and e-mail access will be available only under a teacher's direct supervision. No individual student accounts will be offered. In addition, we will be taking digital images of students (with no names) engaged in classroom activities for display on our school web page.

Please sign and return the Internet Use Agreement Form (other side) and return it to your classroom teacher ASAP. We need a signed form on file for EVERY STUDENT.

If you have any questions or concerns, please feel free to contact NJAT (Tel : 201-627-8383) or admin@njat.us

Rules and Code of Ethics

The use of the Internet is a privilege; therefore, students will be responsible users by:

- Asking permission from the supervising teacher before accessing the Internet;
- Not using e-mail unless the teacher is directly supervising;
- Protecting privacy by not sharing personal information while using the Internet;
- Not using the computer to disturb or harass other computer users by sending unwanted or hurtful mail.

Internet Use Agreement Form

Student:

I understand that computer use at NJAT is designed for educational purposes, and I will abide by the Internet Use Policy. I further understand that if I should commit any violation, my access may be revoked, and school disciplinary action may be taken.

Student's Name: _____

Student's Signature: _____

Parent/Guardian:

As the parent/guardian of this student, I have read the Internet Use Policy. I am aware that my student will be instructed on the acceptable use of NJAT computer network and proper network etiquette. I understand that this access is designed for educational purposes. I recognize it is impossible for Han Al High School to restrict access to all controversial materials, and I will not hold them responsible for material acquired on the network. Further, I accept responsibility for supervision of my student's use of the network when he/she is not in a school setting.

My child/student has my permission to use the Internet at school, while under the supervision of a faculty member.

YES ☐ NO ☐

Signature: _____ Date: _____

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NJAT International Students – U.S. Guardianship Form

Every NJAT international student is required to have an official guardian who lives at the same address physically with the student together. NJAT requires **All NJAT students** live with an adult. The adult could be the official guardian, or other person. When the official guardian and the adult are different, parents have to submit the Host Family Information to NJAT. The official guardian will be considered **the legal responsibility instead of parents** for the student. **This form should be notarized with a notary public signature.**

Requirements for Guardians, and Host Family: 1) Must be over 25 years old, 2) Must be a U.S. Citizen, a legal resident alien, or possess an active U.S. visa, 3) Must be available by phone and email for immediate contact in case of medical or physical emergency, 4) Must be available to academy administration and teachers for conferences or other pertinent meetings concerning the student's education.

Guardian Information:

Mr./Mrs./Ms. _____(last name) _____ (first name)

Home Address: _____

Phone: _____

Primary email address: _____

Host Family Information (Only use this part when the guardian and host family are different)

Mr./Mrs./Ms. _____(last name) _____ (first name)

Home Address: _____

Phone: _____

Primary email address: _____

By signing, I agree that I understand and agree to perform the responsibilities of a U.S. Guardian for (student name). I will remain guardian until this student graduates from NJAT or the parent formally selects another approved representative to meet these obligations.

Guardian Signature (guardian): _____ Host Family Signature (if needed): _____

Date: _____ Date: _____

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STUDENT NAME : **CLASS OF 2021 2022 2023 2024 2025**

This contract becomes effective upon the signature of the parent(s), upon acceptance by New Jersey Academy of Technology and upon payment of the non-refundable registration fee of $500 for returning students, $1,000 for the new students. This contract contains the full agreement of the parties and no representation or assurance, whether verbal or written, shall affect or alter the obligation of either party hereto.

PAYMENTS

$30 late charge will apply to all installments received due date. A **$35** will be charged for **a returned check**. A $30 will be charged for wire. A 5% of the payment will be charged when paid with a credit card. Lost, stolen or ruined textbooks will be charged at the end of the school year. The payment due date is the **15th of July, 2021.**

I (we) understand the student will not be allowed to take semester examinations, nor participate in the next semester classes until the tuition and/or fees in arrears are paid. Also, graduating seniors with tuition and/or fees in arrears will not be issued either a diploma or official transcripts until the balance is paid in full.

In the event tuition and/or fees remain in arrears and unpaid upon the published due date and New Jersey Academy of Technology retains an attorney and/or collection agency to collect monies due, the undersigned parent(s) agree to pay reasonable attorneys' fees and collection agency costs.

Indicate Payment Plan** *(please check)*

Annual ☐ Semester ☐ Quarterly ☐

The Annual tuition plan is ***the only option for international students.*
** Quarterly tuition plan has **$100 additional charge each semester and quarter**.

WITHDRAWAL

I (we) understand that by registering my (our) child for the school year beginning in September 2021, and by paying the non-refundable registration fee, a space will be reserved in the applicable class specifically for my (our) child. I (we) understand that registering my (our) child, without enrolling him/her, or withdrawing during the academic year will cause difficulty, since student spaces cannot or may not be filled. I (we) also recognize that as a private school, New Jersey Academy of Technology's budget is based largely on tuition revenues and contributions. Therefore, I (we) specifically agree that once my (our) child is registered and guaranteed a space, if my (our) child is withdrawn or dismissed for any reason, I am (we are) obligated to forfeit the non-refundable deposit and pay for any outstanding tuition and/or fees. The parents of a student who withdraws before the first day of school will be refunded 100% of the school year full tuition and fees except non-refundable deposit. The parents of a student who withdraws before the end of the first quarter will be refunded 25% of the school year full tuition and fees. The parents of a student who withdraws after the first 2021-2022 quarter will not be refunded any of tuition and fees.

ACKNOWLEDGEMENT

_____ *(initials)* I (we) will read and agree to abide by all policies of Parent/Student Handbook.

_____ *(initials)* I (we) further acknowledge that, pursuant to the Financial Policies section of the Parent/Student Handbook, transcripts, diplomas, grades, etc. will not be released until all financial obligations under this tuition contract have been satisfied.

_____ *(initials)* In the event my (our) child transfers to another school, I (we) understand and agree that transcripts cannot be provided to that school until all financial obligations under this tuition contract have been satisfied.

_____ Signature (Parent / Guardian) Date

_____ Signature (Administrator) Date

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September 7, 2021

RE: Health Admission Package

Dear Parents/ Guardians,

New Jersey Academy of Technology requires annual physicals for all grade levels, whether they participate in sports or not. The following are health related documents that need to be part of the Admissions/Registration Package given to students prior to admissions/registration to NJAT. A 30- day grace period is given to new students, especially if they are coming from other states or countries. The documents are as follow:

1. Preparation Physical Evaluation within the last 365 days. This form must be signed and stamped by a local physician. It must also have the date of examination and the signature, stamp with address, and phone number of physician.

2. State of New Jersey Health History and Appraisal signed and stamped by local physician. Pleased bring your Immunization Record to a local physician. If there's any vaccine missing from the student's record, the physician can administer it at that time.

3. Health History Update Questionnaire. This form must be signed by your parents/guardians

4. Authorization to administer medication in school. This form must be signed and stamped by a local physician as well as a parent/guardian. This letter is for students who need to receive medication either from the school nurse or administrator in charge. The student is required to bring the medication (properly labeled for the student and its proper dosage) and the school will store it until it is needed.

The Administration

PREPARTICIPATION PHYSICAL EVALUATION
HISTORY FORM

Please attach the most recent immunization record for this child.

(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? *If yes, must provide recent exam.		
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

_____

_____

_____

_____

_____

_____

_____

The most recent immunization form for this child is attached ( )

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 _____

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

The most recent immunization form for this child is attached ( )

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 _____

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

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 _____

Address _____ Phone _____

Signature of physician, APN, PA _____

The most recent immunization form for this child is attached ( )

HE0503 9-2681/0410

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

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 _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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). The most recent immunization form for this child is attached ( )

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_____

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

STATE OF NEW JERSEY
HEALTH HISTORY AND APPRAISAL

IMMUNIZATION REGISTRY NUMBER

Name of Child (Last, First, M.I.)	Date of Birth (Mo/Day/Yr)	Sex ☐ Male ☐ Female

PARENT OR GUARDIAN	NAME	TELEPHONE NO.
	ADDRESS	

VACCINE TYPE	1st Dose Mo/Day/Yr	2nd Dose Mo/Day/Yr	3rd Dose Mo/Day/Yr	4th Dose Mo/Day/Yr	5th Dose Mo/Day/Yr
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination *(If Td or DT, indicate in corner box)*					
Tdap					
POLIO – INACTIVATED POLIO VACCINE (IPV) *If oral vaccine, indicate (OPV) in corner box*					
MEASLES, MUMPS, RUBELLA (MMR)					
HAEMOPHILUS B (HIB)**					
HEPATITIS B					
VARICELLA					
PNEUMOCOCCAL CONJUGATE **					
MENINGOCOCCAL					
HEPATITIS A ***					
HPV (HUMAN PAPILLOMAVIRUS) ***					
OTHER					
OTHER					

LEAD SCREENING	
Test Date	Result

Document below single antigen vaccine receipt, serology titers, or varicella disease history

Hepatitis B	Date:	Titer:
Varicella	Date:	Titer:
Measles	Date:	Titer:
Mumps	Date:	Titer:
Rubella	Date:	Titer:

☐ Provisional admission attached–Date Granted:_____ ☐ Medical exemption attached ☐ Religious exemption attached

HISTORY	YEAR	HISTORY	YEAR	HISTORY	YEAR	HISTORY	YEAR
FOOD ALLERGIES		DIABETES		LYME DISEASE		JUVENILE RHEUMATOID ARTHRITIS	
NON-FOOD/NON-DRUG ALLERGIES		INFLUENZA (FLU)		MONONUCLEOSIS		AUTISM SPECTRUM DISORDERS	
		OTHER		NEUROMUSC. DISORDER		HEMATOLOGICAL DISORDERS	
ASTHMA		DRUG ALLERGIES		CHRONIC OTITIS MEDIA		ADD/ADHD	
CONGENITAL DISORDER		HEART DISEASE		AUTO IMMUNE DISORDERS		CONCUSSION/TBI	
CONVULSIVE DISORDER		HEPATITIS		STREP INFECTIONS			

HEALTH SCREENING CODE: N = Normal; R = Referred; T = Under Treatment; C = See Comments

Grade/Age															
Date															
Height															
Weight															
BMI***															
Blood Pressure															
VISION With correction R															
VISION With correction L															
VISION With correction BOTH															
VISION Without correction R															
VISION Without correction L															
VISION Without correction BOTH															
VISION Muscle Balance															
HEARING Date															
HEARING Pure Tone R															
HEARING Pure Tone L															

Color Perception Date Results

BIENNIAL SCOLIOSIS SCREENING (Beginning at Age 10) Date _____ Date _____ Date _____ Date _____ Date _____

Referred for abnormal result ☐ ☐ ☐ ☐ ☐

TB Screening (Mantoux or IGRA Test)

	Date	Date
Tested		
Read		
Mantoux Result (MM) or		
IGRA Result		

Chest X-Ray

	Date	Result: Normal	Result: Abnormal

Medication
Reactor No Rx ☐
Date Started _____
Date Completed _____

**REQUIRED FOR DAY/CHILD CARE ENROLLEES (2 Months-5th Birthday Only) ***Not Required

PHYSICAL EXAMINATIONS

Date	Grade/Age	Type of Exam	Significant Findings	Medical Provider

Date	RECORD: Findings and Recommendations of Physicians including medications, operations and injuries; Modification of School Program; Referrals and Follow-up; Conference with Parents, Teachers; Counseling with Student. Individual Nurses notes must be attached.	SIGNATURE

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 ☐ No ☐
9. Started or stopped taking any over-the-counter or prescribed medications? Yes ☐ No ☐
10. Been diagnosed with Coronavirus (COVID-19)? Yes ☐ No ☐
    If diagnosed with Coronavirus (COVID-19), was your son/daughter symptomatic? Yes ☐ No ☐
    If diagnosed with Coronavirus (COVID-19), was your son/daughter hospitalized? Yes ☐ No ☐
11. Has any member of the student-athlete's household been diagnosed with Coronavirus (COVID-19)? Yes ☐ No ☐

Date: _____ Signature of parent/guardian: _____

Please Return Completed Form to the School Nurse's Office

NURSE ADMINISTRATION OF MEDICATION IN SCHOOL

NAME OF STUDENT_____GRADE_____

DIAGNOSIS_____

MEDICATION_____

DOSAGE_____FREQUENCY_____

DIRECTIONS_____

POSSIBLE SIDE EFFECTS_____

I authorize the School Nurse to administer the above medication:

_____ _____

Signature of M.D. Date Signature of Parent/Guardian Date

_____ _____

Physician's Street Address Town & Zip Code

_____ _____

Telephone Number

SELF-ADMINISTRATION OF MEDICATION IN SCHOOL

I certify that this student has asthma or another potentially life-threatening illness and is permitted to self-administer the above medication. He/she has been instructed in the proper techniques of self-administration and has demonstrated competence in this technique.

_____ _____

Signature of Prescribing Physician Date

_____ _____

Address Telephone Number

****

I authorize my child to self-administer the above medication. This permission includes self-administration of medication during regular school hours and at other times when my child is participating in a school-related event. I understand that the district, school, school nurse and other school employees shall incur no liability as a result of any injury arising from the self-administration of this medication and that I will indemnify and hold harmless the district, school, school nurses and other school employees against any claims arising from the self-administration of medication by my child.

Date_____Parent/Guardian Signature_____

BOTTOM PORTION OF THIS FORM TO BE FILLED OUT <u>ONLY</u> IF STUDENT SELF-MEDICATES.