FROM THE DESK OF THE SCHOOL NURSE
School Year 2019-2020

Dear Parents,

Our goal is to provide for the health and well being of your child while s/he is attending school. Please read this letter carefully, and submit the necessary completed forms to the school office. **As parents often require copies of these forms (for sports, etc.), please make sure to keep necessary copies for your records.**

No child may enter the classroom until the school has received a copy of the child's immunization history and physical exam form.

IMMUNIZATIONS

The New Jersey State Department of Health requires that all children attending school must have a complete record of immunizations on file.

The State of New Jersey can issue a costly fine for each immunization record that is not received. All missing inoculations must be completed in a timely manner. Check with your pediatrician to make sure that your child's immunizations are up to date. Any time any of your school age children receive a vaccination, please notify the school so we can update your child's file as per NJ Health Department
regulations.

NEW STUDENTS attending the Noble Leadership Academy for the first time should have a record of their immunizations submitted before school begins.

ALL STUDENTS UP TO THE AGE OF 5: In 2008, the New Jersey Health Department mandated an annual influenza ("flu") vaccination for children attending preschool (6-59 months of age) by December 31st of each year. ***Flu Records are required to be submitted by December 15, 2019.***

KINDERGARTEN: Students are required to have additional immunizations when they reach 4 years of age.

6th GRADE: Students are required to have additional immunizations when they reach 11 years of age/6th grade. Tdap (must be 5 years since last Dtap) and Meningococcal vaccinations.

PHYSICAL EXAMS

Parents are advised to bring their children for a yearly physical (although not required by law) for the optimal development.

Physicals in our school are mandated for: **ALL NEW STUDENTS-REGARDLESS OF THEIR GRADE**, **Kindergarten** and **6th grade** students. The enclosed "*Universal Child Health Record"* is the preferred form; however, any physical that was completed in this calendar year is acceptable to fulfill this requirement. Please submit this form to the school office before school begins.

MEDICATION

Enclosed is a medication consent form, *"Authorization to Administer Medications/Remedies to Students,"* for you and your physician to fill out in order to authorize the administration of any/all medication that may need to be given during school hours. This includes over the counter remedies.

(OVER, PLEASE)

Should your child need antibiotics/medication for any given period of time, a doctor's note must accompany the medication with the diagnoses, exact dose, time, route of administration and duration of treatment. In addition, ***written*** parental consent must be given.

MEDICAL CONDITION AND/OR ALLERGIES

If your child has a medical condition that we should be aware of, such as asthma, diabetes, severe food allergies, or any other condition that might cause an emergency during school hours, kindly have your physician fill out the attached relevant forms: *"Allergy Treatment Plan," "Asthma Action Plan," "Emergency Form for Children with Special Medical Needs,"* and/or "*Request for Self-Administration of Medication."*

Students who have a nut, sesame, or any other allergy for which an epipen is needed, **two epipens** must be stored at the school.

Medication will not be administered to any student without the proper authorization from the child's physician and parent. All medication orders **must be renewed YEARLY.** All medication and supplies must be brought to the school office.

All forms can be faxed by you or your doctor to the school at 973-685-2549 or emailed to info@noblela.org.

Thank you.

Fondly,
School Nurse
Nurse@noblela.org

AUTHORIZATION TO ADMINISTER MEDICATIONS/REMEDIES TO STUDENTS

School Year 2019-2020

One per child

(please make/request additional copies as needed)

Last Name:_____ First Name:_____

Grade:_____ D.O.B.:_____

I hereby authorize Noble Leadership nurses, principals, or their designees to administer the following medication/remedies to my child.

Name of Medication or Generic Equivalent	Route	Dosage	Schedule	Put an X only if med is <u>not to be</u> <u>given.</u>
Tylenol	PO	Per labels instruction by age/weight	every 4-5 hrs as needed for discomfort or elevated temp	
Advil	PO	Per labels instruction by age/weight	every 6 hrs as needed for discomfort or elevated temperature	
Benadryl	PO	Per labels instruction by age/weight	every 6 hrs as needed for discomfort of allergic reaction	
Chewable Anti-Acid (Tums)	PO	5-11 years one tablet 12 yrs+ 2 tablets	every 6 hrs as needed	
Anti-Itch Lotion (Calamine)	Topical	As needed	As needed	

_____ _____

Parent/Guardian Name (printed) Parent/Guardian Signature

_____ _____

Physician Name (printed) Physician Signature

Noble Leadership Academy Inc.
123 Jefferson Street, Passaic, NJ 07055
|**T:** 973 685 2550 |**F:** 973 685 2549 |**E:** info@noblela.org |**W:** www.noblela.org

ALLERGY TREATMENT PLAN

Last Name:_____ **First Name:**_____
Grade:_____ **D.O.B.:**_____

Asthmatic: ☐ Yes* ☐No
* Higher risk for severe reaction; please fill out **Asthma Form**

ALLERGIC TO:	If exposed to allergen and there are NO symptoms or mild localized symptoms:	If anaphylactic symptoms are shown*
	□EpiPen □ EpiPen Jr □Antihistamine Medication: Dose: Route:	EPIPEN/ EPIPEN JR
	□EpiPen □ EpiPen Jr □Antihistamine Medication: Dose: Route:	EPIPEN/ EPIPEN JR

Note: Nut and sesame Allergies can have severe reactions, and will be treated with an epipen even if no symptoms are shown.
*Anaphylactic symptoms: Itching, tingling, or swelling of lips, tongue, mouth; Hives, itchy rash, swelling of the face or extremities; Nausea, abdominal cramps, vomiting, diarrhea; Tightening of throat, hoarseness, hacking cough; Shortness of breath, repetitive coughing, wheezing; thread pulse, low blood pressure, fainting, pale, blueness.

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, AUTHORIZATION IS GIVEN TO MEDICATE OR TO TAKE CHILD TO MEDICAL FACILITY!

_____ _____
Parent Signature Date

_____ _____
Physician Signature Date

- -

Emergency Contact Information, (including parents) in the order they should be called:

Name	Phone Numbers	Relationship to child

Students who have an allergy for which an epipen is needed must have a clearly labeled epipen stored in the school office. Please check the expiration dates of all medication given in.

EMERGENCY FORM FOR CHILDREN
WITH SPECIAL MEDICAL NEEDS

(To be filled out only if your child has special medical needs. For allergies or asthma, please use those forms.)

Last Name:_____ First Name:_____

Grade:_____ D.O.B._____

Physician Student sees for this condition:_____ Phone:_____

Other Physician:_____ Phone:_____

MEDICAL SITUATION
Diagnosis:
Brief description of how this condition can affect your child and how we can be of assistance:
Activity Restrictions:
Currently taking Medication: □ Yes □ No
Medication Regimen (including medication not usually given in school):

If your child may need any medication, please fill out the section below. Please ensure that the office has an updated supply of all the medication/equipment. If the child will be administering the medication himself, please fill out the appropriate form.

AUTHORIZATION TO ADMINISTER MEDICATION IN SCHOOL		
Symptoms that require medication:		
Medication:	Dose:	How often:
	Purpose of Drug:	Possible Side Effects:
Medication:	Dose:	How often:
	Purpose of Drug:	Possible Side Effects:

_____ _____

Parent/Guardian Signature Date

_____ _____

Physician's Signature Date

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REQUEST FOR SELF ADMINISTRATION OF MEDICATION

Last Name:_____ First Name:_____
Grade:_____ D.O.B.:_____

Asthmas Inhalers_____ Insect Sting Kit_____

To Be Completed By Physician: (Please Print)
I am requesting that the above-named student be allowed to self-administer the following medications:

Name of Medication:_____
Diagnosis for which medication is given:_____
Prescribed dosage and time to be taken:_____
If Daily, at what time:_____
If "When Needed," describe indications:_____
How soon can it be repeated:_____
Possible side effects and/or special precautions to be taken:
_____
_____
Length of time this medication is prescribed:_____
Conditions under which self-administration will take place:
□ Independently. Child has been trained and is proficient in self-administrating.
□ Under the supervision of school nurse/school staff
Medication should be: □ stored in the nurse's office or designated area
□ in the possession of student

_____ _____
Physician's Name (Print) Physician's Signature
_____ _____
Telephone Number Date

To Be Completed By Parent: I give permission for my child to self-administer the medication described above. I will notify the school nurse if this medication is no longer required or self-administration is no longer directed by the physician.

The medication is to be provided by me in the original labeled container. To my knowledge my child is not allergic to this medication.

I hereby release and hold harmless the Board, its agents, servants, and employees from any and all liability for injuries or other damage which may result to the student, his/her servants and representatives which may result from administration of the medication.

_____ _____
Parent/Guardian Signature Date