EAST RUTHERFORD SCHOOL DISTRICT
100 Uhland Street
East Rutherford, NJ 07073
201-804-3100

Welcome to the East Rutherford School District. The Student Registration Checklist is intended to assist you with the registration process.

( ) Birth certificate of Student

( ) Proof of Residency (property deed, residential tax bill or lease) and any two (2) of the following (telephone bill, gas/electric bill, cable bill, etc.)

( ) Personal Identification of Parent/Guardian

( ) Proof of Guardianship (court papers or other legal document)

( ) Record of Physical Examination

( ) Record of Immunizations

( ) Transfer Card

( ) School Report Card/Transcript

( ) Other School Records

EAST RUTHERFORD PUBLIC SCHOOLS
Student Enrollment

STUDENT'S INFORMATION: School:_____ Grade_____

Last Name:_____ First Name:_____ Middle:_____

Home Address:_____

Home Phone Number:_____

Date of Birth:_____ Place of Birth:_____ Sex:_____
(City/State/Country)

Verification:_____ B.C.:_____ Other:_____

Date of Entrance into the United States:_____

Language Spoken at Home:_____ Is ESL Needed: _____Yes _____NO

Name, Address & Phone Number of School Previously Attended:_____

_____

FAMILY INFORMATION:

Father's/Guardian Full Name:_____

Address (If Different):_____

( )Check if Address is Different and Should Receive Correspondence Concerning Child

E-Mail Address:_____

Home Telephone(If Different):_____ Cell Phone Number:_____

Employer:_____ Work Number:_____

Mother's/Guardian's Full Name:_____

Address (If Different):_____

( )Check if Address is Different and Should Receive Correspondence Concerning Child

E-Mail Address:_____

Home Telephone(If Different):_____ Cell Phone Number:_____

Employer:_____ Work Number:_____

_____

Marital Status of Parent(s): Married:____ Single:____ Divorced:____ Widowed:____

Stepfather's Name:_____ Telephone Number:_____

Stepmother's Name:_____ Telephone Number:_____

Number of children in Household:____ Ages of All Brothers and Sisters:_____

_____

Name and Address of Emergency Contact Person:_____

_____

Relationship to Child:_____ Telephone Number(Home):_____

Telephone Number (Cell):_____ Telephone Number (Work):_____

Physician's Name:_____ Telephone Number:_____

State any family circumstances (divorce, separation, etc.) and or custodial arrangements that the school should know. A COPY OF THE LEGAL DOCUMENTS WHICH ESTABLISHED THESE ARRANGEMENTS MUST BE PROVIDED TO THE SCHOOL.

_____

_____

Has the child ever been evaluated by Child Study Team_____Yes_____No

If yes, are they classified? _____Yes_____No If yes, please submit documentation.

The New Jersey State Department of Education and the Federal Government requires the following information:
What is the student's racial/ethnic code? More than one race category may be marked.

_____ White, A student having origins of the original peoples of Europe, the Middle East or North Africa.

_____ Black or African American, A student having origins in any of the black racial groups of Africa.

_____ American Indian or Alaska Native, A student having origins in any of the original people of North and South America (including Central America) and who maintains a tribal affiliation or community attachment.

_____ Native American or Other Pacific Islander, A student having origins in any of the originals peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

_____ Asian, A Student having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.

Yes or No – Hispanic or Latino, a student of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

_____ _____

Date Signature of Parent/Guardian

EAST RUTHERFORD SCHOOL DISTRICT
Uhland and Grove Streets
East Rutherford, New Jersey 07073
201-804-3100

FORM 1 SECTION A (DOMICILE)

(PLEASE COMPLETE ONE FORM FOR EACH CHILD

Complete this section if the student is living with a parent or guardian whose permanent home address is given on the registration form and is located in the district. If you are the student's guardian, or will be the guardian of a student from out of state you will be asked to provide official documentation proving guardianship.

Name of Person Enrolling Student: _____

Name of Student: _____ Grade: _____

School: _____

Home Address: _____

Home Telephone Number: _____

How long have you lived in this home? (years) _____

Do you own this home _____ Yes _____ No

If you are a tenant: Do you pay rent? _____ Yes _____ No (If no, you must complete a non-rent paying affidavit.

Do you have a written lease? _____ Yes _____ No

Do you have any present intention of moving from this home _____ Yes _____ No
If so, when and where? _____

Do you have a residence elsewhere? _____ Yes _____ No
If so, where and when do you live there? _____

SECTION A.1 (DOMICILE) (complete this section if applicable)

If the student's parents are domiciled in different districts, regardless of which parent has legal custody, please answer the following questions:

Is there a court order or written agreement between the parents designating the district for school attendance and if so, where does it require the student attend school?

Yes _____ No _____ (if yes, please provide this document)
Does the student reside with one parent for the entire year? _____ Yes _____ No
If yes, with which parent and at what address? _____
If no, for what portion of the year does the student reside with each parent and at what address? _____

If the student lives with both parents on an equal time, alternating basis, with which parent did the student reside on the last school day prior to October 16? _____

SECTION A.2 (DOMICILE) (Complete this section if applicable)
If you are claiming to be an emancipated minor, are you living independently in your own permanent home in the district? _____ Yes _____ No
If yes, please describe the proof that you will provide in addition to those demonstrating domicile, to demonstrate that you are not in the care and custody of a parent/guardian.

DO NOT WRITE IN THIS BOX

For office use ONLY: Date received_____ by _____

- ☐ Birth Certificate or Passport
- ☐ Category 1 (current tax bill, mortgage statement, lease agreement)
- ☐ Category 2 (current utility bill, phone bill)
- ☐ Category 3 (current financial acct/bank statement, paystub with address, state agency document)
- ☐ Category 4 (if applicable) (proof of guardianship, custody documents, state agency placement documents, affidavits of support/non support)

☐ Registration COMPLETED ☐ Genesis

EAST RUTHERFORD PUBLIC SCHOOLS
Office of Student Services
100 Uhland Street
East Rutherford, NJ 07073
Phone: (201) 804-3100 ♦ Fax: (201) 933-1845
www.erboe.net

Home Language Survey Form

Introduction

This survey is the first of three steps to identify whether or not a student is eligible to be an English language learner (ELL). Start with "Question 1" and continue until the HLS is complete. Select the answer for each question and follow the directions.

Student Information

Student name: _____ Student birth date: _____

Street Address: _____ City: _____

State: _____ Zip Code: _____

Phone number: _____

Survey Questions:

Question 1: What was the first language used by the student?

_____ A language other than English (Proceed to question 2a)

_____ English (Proceed to question 2b)

Question 2a: At home, does the student hear or use a language other than English more than half of the time? _____ Yes. (Proceed to question 7) _____ No. (Proceed to question 4)

Question 2b: At home, does the student hear or use a language other than English more than half of the time? ____ Yes. (Proceed to question 4) _____No. (Proceed to question 3)

Question 3: Does the student understand a language other than English?

_____ Yes. (Proceed to question 4) _____ No. (Proceed to 9).

PLEASE CONTINUE ON NEXT PAGE

Question 4: When interacting with his/her parents or guardians, does the student use a language other than English more than half of the time? _____ Yes (Proceed to question 7) _____ No (Proceed to question 5)

Question 5: When interacting with caregivers other than their parents or guardians, does the student use a language other than English more than half of the time? _____Yes _____No

Question 6: Has the student recently moved from another school district/charter school where he/she was identified as an English language learner? _____Yes _____No

Question 7: What are the home languages spoken?

1.
2.
3.
4.

Home Language Survey is complete.

EAST RUTHERFORD PUBLIC SCHOOLS

East Rutherford, NJ 07073

Alfred S. Faust Intermediate School
100 Uhland Street
East Rutherford, NJ 07073
201-804-3100

Regina Barrale, Principal **Grades 5-8**

Date_____

To Whom It May Concern:

_____ has registered at _____ School on

_____. We would appreciate the following information.

Scholastic Records _____

Health Records _____

Transfer Slip _____

Child Study Team Records _____

AUTHORIZATION IS HEREBY GRANTED FOR THE RELEASE OF ALL INFORMATION, INCLUDING COPIES OF THE CHILD STUDY TEAM EVALUATIONS, FROM THE RECORDS OF MY CHILD TO THE EAST RUTHERFORD PUBLIC SCHOOLS.

_____ _____

Signature of Parent/Guardian **Date**

Thank you for your cooperation.

Sincerely,

Regina Barrale
Principal

McKenzie School
Joann Saab RN, MSN, APN, CSN
Certified School Nurse
Ph – 201-531-1235 ext. 4006
Fax – 201-531-1491
Jsaab@erboe.net

East Rutherford School District
Nursing Department
East Rutherford, New Jersey 07073

A.S.Faust School
Kristin Pacelli RN, BSN,CSN
Ph-201-804-3100 ext. 3005
Kpacelli@erboe.net

DATE: _____

Dear Parent/Guardian:

Due to the fact that the School Nurse is not always available during the summer months, your child's registration is contingent upon the receipt of all necessary Health and Medical information.

This information includes:

1. Health history, completed and signed by a Parent or Legal Guardian
2. Immunizations
3. Physical examination performed by a private Health Care Provider. (An M.D., D.O., or Nurse Practitioner).

If your child has a specific medical problem or needs to take medicine in school, this must also be addressed before school begins due to the fact that no medication is given in school without an order form signed by the Healthcare Provider and the Parent/Guardian.

You will be notified as to the status of your child registration either by telephone or by mail.

No child will be permitted to begin school without a complete medical file.

EAST RUTHERFORD PUBLIC SCHOOLS
MEDICAL DEPARTMENT

ALFRED S. FAUST SCHOOL
201-804-9694

MCKENZIE SCHOOL
201-531-1235 x2

Authorization for Exchange of Confidential Information

STUDENT_____ DATE_____
DATE OF BIRTH_____ TEACHER_____

As Parent/Guardian of the above named student, I hereby authorize the release of pertinent medical information (medical conditions, allergies, and/or medication regimes) to be exchanged among the appropriate professional staff involved with my child. This consent is valid for the 2017-2018 school year and is intended to allow the school staff to better serve my child.

Signature of Parent/Guardian **Date**

McKenzie School
Joann Saab RN, MSN, APN, CSN
Certified School Nurse
Ph – 201-531-1235 ext. 4006
Fax – 201-531-1491
Jsaab@erboe.net

East Rutherford School District
Nursing Department
East Rutherford, New Jersey 07073

A.S.Faust School
Kristin Pacelli RN, BSN,CSN
Ph-201-804-3100 ext. 3005
Kpacelli@erboe.net

HEALTH APPRAISAL

Name: _____ Birth Date: _____

Address: _____ School: _____

Parent(s) \Guardian(s) Signature _____ Date of Entry_____

SIGNIFICANT *HEALTH* HISTORY

Has your child had any of the following diseases? Give Dates.

Allergy_____
Asthma_____
Convulsions_____
Chicken Pox_____
Diabetes_____
Ear infection/fluid_____
Eczema/contact dermatitis_____
Heart disease/murmur_____
Rheumatic fever_____
Kidney/bladder problems_____
Lyme disease_____
Meningitis_____
Pneumonia_____
Scarlet fever_____
Tuberculosis_____
Whooping cough/pertussis_____
Other (specify) _____

Has your child had any of the following.

Accidents_____

_____

Operations_____

_____

Hospitalizations_____

_____

Dental treatment_____

Has your child traveled out of the Country? Yes ___ No ___
If Yes, Where? _____

Place of Birth: _____

Does your child have any handicapping conditions?

congenital deformities _____
Hearing_____
Vision _____
Orthopedic_____
Birth injury/defect_____

GROWTH AND DEVELOPMENT

Did your child have a normal birth? _____ Caesarean section? _____
Weight at birth _____ Age of walking _____ Age of first words _____
Age of first sentence_____

Does your child have brothers and/or sisters? Names and ages_____

_____

Did your child have any special growth and/or development problems in the pre-school years?_____

Does your child show good coordination? _____

Does your child show preference for his right or left hand? _____

Does your child understand and respond to directions and questions? _____

_____

Does your child understand and/or speak a language other than *English?* _____

_____

Has your child had high fevers and/or frequent illnesses? _____

_____

What medications (prescribed or over-the counter) have been or are currently given to your child? _____

_____

What medical treatment, if any, is your child presently receiving? _____

_____

Does your child have any of the following: bedwetting, disturbed sleeping patterns, special fears, nightmares, finger sucking, nail biting, nervous tendencies, sensitive, over active, cries easily, poor eating habits, rocking. pattern, temper tantrums, other?

Please comment on those conditions that pertain to your child _____

_____

_____

Physician's name-, _____ Address, _____

Has your child had his/her speech/language/hearing evaluated? _____ When? _____

Name.- _____ Address- _____

Has your child seen a psychiatrist or psychologist? _____ When? _____

Name: _____ Address: _____

L, Your opinion is your child healthy? _____

Is there any other information that would be helpful in planning for your child's school experience? _____

_____

Date: _____ Parent/Guardian's Signature-, _____

Indicate the number of a relative, neighbor or friend nearest your home who could be contacted in case of an emergency,

Name: _____ Relationship to child: _____

Address: _____ Telephone _____

East Rutherford Public Schools
East Rutherford, NJ 07073

Physical Examination

To Be Filled Out By Family Physician **Date**_____

Pupil's Name (Last) (First) _____ Date of Birth _____

Telephone Number _____ Address _____

Teacher _____ Grade _____ School _____

VACCINE TYPE	DISEASE MO/DAY/YR	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	MO/DAY/YR
DIPTHERIA, TETANUS, PERTUSSIS (DTP) / DTaP							
POLIO – ORAL POLIO VACCINE (OPV) / IPV							
MEASLES, MUMPS, RUBELLA (MMR)							
MEASLES ONLY							
INFLUENZA							
PNEUMOCOCCAL							
HAEMOPHILUS B (HIB)							
HEPATITIS B							
VARICELLA							
MENINGOCOCCAL							

TB Screening (Mantoux Test)	Date	Date	Date
Tested			
Read			
Result (MM)			

Chest X-Ray	Result	
Date	Normal	Abnormal

Therapy _____
Case Reactor
Date Started _____
Date Completed _____

Height _____ Weight _____ Blood Pressure _____ Allergies _____

Eyes _____ Vision (R) _____ (L) _____
Ears _____
Lymph Nodes _____
Thyroid _____
Nose _____
Throat _____
Teeth & Mouth _____
Heart _____
Lungs _____

Genito Urinary _____
Orthopedic _____
Scoliosis _____
Skin (non-comm) _____
Epilepsy _____
Nervous System _____
Nutrition _____
Hernia _____
Other _____

Has this child any developmental disability, which may impede academic performance? _____

Physical Education Participation: Full _____ Limited _____ None _____
Please explain: _____

Is child being treated for any illness, disability, or injury? Please give any pertinent medical history: _____

Does this child take medication on a regular basis? Explain: _____

Physician's Name _____ Physician's Stamp _____

HEARING SCREENING
By Private Medical Doctor

PRE-KINDERGARTEN_____

Name_____

Date_____

PASS_____ RECHECK_____

VISION SCREENING
By Private Medical Doctor

PRE-KINDERGARTEN_____

Name_____

Date_____

PASS_____ RECHECK_____

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PARENT/GUARDIAN PERMISSION FOR ADMINISTRATION OF EPINEPHRINE (EPI-PEN) BY UNLICENSED SCHOOL PERSONNEL IN THE ABSENCE OF THE SCHOOL NURSE

Student's Name: _____ DOB: _____

Address: _____ Grade: _____

Parent/Guardian Name: _____

Home Phone: _____ Other Phone(s): _____

If Parent/Guardian is unavailable in emergency, contact:
Name: _____
Phone(s): _____ Relationship: _____

My son/daughter has the following allergy(s) which may require treatment with epinephrine (Epi-pen), according to my child's physician:

_____

****

CONSENT FOR TREATMENT

I give permission to allow the administration of epinephrine by auto-injection (Epi-pen) by
the school nurse or, in the absence of the school nurse, by an unlicensed member of the school staff who has been trained and delegated by the school nurse to my son/daughter, in the event of an emergency. I also allow the school nurse to share with appropriate school personnel information relative to this medication administration plan.

_____ _____
Signature of Parent/Guardian Date

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ **No**

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Shortness of breath, wheezing, repetitive cough

HEART
Pale or bluish skin, faintness, weak pulse, dizziness

THROAT
Tight or hoarse throat, trouble breathing or swallowing

MOUTH
Significant swelling of the tongue or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy or runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

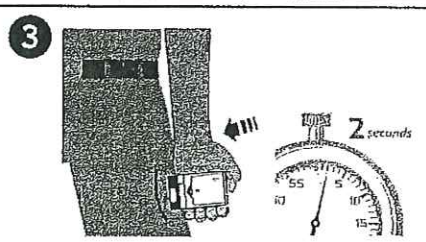
PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2018

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

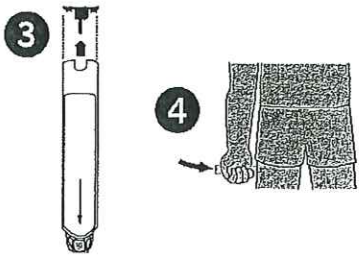
HOW TO USE AUVI-Q® (EPINEPRHINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
5. Call 911 and get emergency medical help right away.



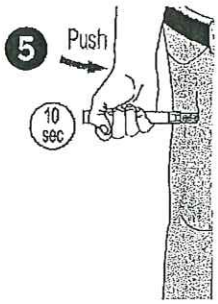
HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, IMPAX LABORATORIES

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip.
3. Grasp the auto-injector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. Call 911 and get emergency medical help right away.



ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2018

McKenzie School
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AUTHORIZATION FOR ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

To the Parent/Guardian: Students receiving or taking any medication at school must have written order from a doctor or dentist licensed to practice in New Jersey, as well as a parental permission form on file in the office of the School Nurse. If the Nurse does not know what medications a student may be taking, she/he cannot function effectively in the event of an emergency situation. In the absence of the School Nurse, a teacher or principal who has volunteered to be trained in the administration of certain medications, according to State and School District Policy, may give the medication to the student. In the event that no school personnel volunteer to accept this responsibility, it must revert to the parent/guardian. Medication must remain in the container in which it was purchased.

I have read and understand the above statement, and give my permission to the School Nurse or designated school staff to administer medication to my child following the instructions below. I understand that unused medication must be picked up no later than two weeks after the finish date, or the medication will be destroyed in accordance with the law.

_____ _____
(Parent/Guardian Signature) (Date)

To the Physician: Please fill in the following section.

_____ is to receive _____

(Patient/Student) (Name of Medication)

Dose _____ Frequency _____

Reason for prescribing _____

Start date _____ Finish date _____

Side effects to watch for _____

Is this a controlled drug? Yes _____ No_____

_____ _____

M.D. Signature & Stamp Phone

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. (AGE 7-9 YEARS): 3 doses of Td or any previously administered combination of DTP, DTaP, and DT is 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. 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. 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. (AGE 7 or OLDER): Any 3 doses.	Either Inactivated Polio Vaccine (IPV) or Oral Polio Vaccine (OPV) separately or in combination is acceptable. Polio vaccine is not required of pupils 18 years of age or older. 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. If born on or after 1-1-90, 2 doses of a live Measles-containing vaccine on or after the first birthday. 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. Any child entering Kindergarten needs 2 doses. 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. Laboratory evidence of immunity is also acceptable. 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. 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. 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. 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. 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 (AGE 12-59 MONTHS)[2]: 1 dose	Mandated only for children enrolled in child care, pre-school, or pre-Kindergarten. [1] Minimum of 2 doses of Hib vaccine is needed if between the ages of 2-11 months. [2] Minimum of 1 dose of Hib vaccine is needed after the first birthday. 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. Laboratory evidence of immunity is also acceptable.
PNEUMO-COCCAL	(AGE 2-11 MONTHS)[1]: 2 doses (AGE 12-59 MONTHS)[2]: 1 dose	Mandated only for children enrolled in child care, pre-school, or pre-Kindergarten. [1] Minimum of 2 doses of Pneumococcal vaccine is needed if between the ages of 2-11 months. [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] (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 9-1-06 and born on or after 1-1-97. [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. 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-

THE FOLLOWING COUNTRIES HAVE A LOW INCIDENCE OF TB AND REQUIRE NO TB TESTING

Albania
America Samoa
Andorra
Antigua and Barbuda
Australia
Austria
Barbados
Belgium
Bermuda
British Virgin Islands
Canada
Cayman Islands
Chile
Cook Islands
Costa Rica
Cuba
Cyprus
Czech Republic
Denmark
Dominica
Finland
France
Germany
Greece
Greenland
Grenada
Iceland
Ireland
Israel
Italy
Hungary
Jamaica
Jordan
Lebanon
Luxembourg
Malta
Monaco
Montserrat
Netherlands
Netherlands Antilles
New Zealand
North Ireland
Norway
Oman
Puerto Rico
Saint Kitts and Nevis
St. Lucia
Samoa
San Marino
Slovakia
Slovenia
Sweden
Switzerland
Trinidad and Tobago
Turks and Caicos Islands
United Arab Emirates
United Kingdom of Great Britain and Northern Ireland
United States of America
United States Virgin Islands

Students entering a U.S. school for the first time in New Jersey or transferring into a New Jersey school from ANY country NOT listed above must receive an IGRA or Mantoux tuberculin skin test unless they meet an exemption criterion.

Asthma Treatment Plan – Student

(This asthma action plan meets NJ Law N.J.S.A. 18A:40-12.8) **(Physician's Orders)**

The Pediatric/Adult Asthma Coalition of New Jersey
"Your Pathway to Asthma Control"
NJCAI approved Plan available at www.pacnj.org

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NJ Health

(Please Print)

Name	Date of Birth	Effective Date
Doctor	Parent/Guardian (if applicable)	Emergency Contact
Phone	Phone	Phone

HEALTHY (Green Zone)

Take daily control medicine(s). Some inhalers may be more effective with a "spacer" – use if directed.

You have *all* of these:
- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work, exercise, and play

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Advair® HFA ☐ 45, ☐ 115, ☐ 230	2 puffs twice a day
☐ Aerospan™	☐ 1 ☐ 2 puffs twice a day
☐ Alvesco® ☐ 80, ☐ 160	☐ 1 ☐ 2 puffs twice a day
☐ Dulera® ☐ 100, ☐ 200	2 puffs twice a day
☐ Flovent® ☐ 44, ☐ 110, ☐ 220	2 puffs twice a day
☐ Qvar® ☐ 40, ☐ 80	☐ 1 ☐ 2 puffs twice a day
☐ Symbicort® ☐ 80, ☐ 160	☐ 1 ☐ 2 puffs twice a day
☐ Advair Diskus® ☐ 100, ☐ 250, ☐ 500	1 inhalation twice a day
☐ Asmanex® Twisthaler® ☐ 110, ☐ 220	☐ 1 ☐ 2 inhalations ☐ once ☐ twice a day
☐ Flovent® Diskus® ☐ 50 ☐ 100 ☐ 250	1 inhalation twice a day
☐ Pulmicort Flexhaler® ☐ 90, ☐ 180	☐ 1 ☐ 2 inhalations ☐ once ☐ twice a day
☐ Pulmicort Respules® (Budesonide) ☐ 0.25, ☐ 0.5, ☐ 1.0	1 unit nebulized ☐ once ☐ twice a day
☐ Singulair® (Montelukast) ☐ 4, ☐ 5, ☐ 10 mg	1 tablet daily
☐ Other	
☐ None	

And/or Peak flow above _____

Remember to rinse your mouth after taking inhaled medicine.

If exercise triggers your asthma, take _____ ___ puff(s) ____ minutes before exercise.

CAUTION (Yellow Zone)

Continue daily control medicine(s) and ADD quick-relief medicine(s).

You have *any* of these:
- Cough
- Mild wheeze
- Tight chest
- Coughing at night
- Other:_____

If quick-relief medicine does not help within 15-20 minutes or has been used more than 2 times and symptoms persist, call your doctor or go to the emergency room.

And/or Peak flow from_____ to_____

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	2 puffs every 4 hours as needed
☐ Xopenex®	2 puffs every 4 hours as needed
☐ Albuterol ☐ 1.25, ☐ 2.5 mg	1 unit nebulized every 4 hours as needed
☐ Duoneb®	1 unit nebulized every 4 hours as needed
☐ Xopenex® (Levalbuterol) ☐ 0.31, ☐ 0.63, ☐ 1.25 mg	1 unit nebulized every 4 hours as needed
☐ Combivent Respimat®	1 inhalation 4 times a day
☐ Increase the dose of, or add:	
☐ Other	

- **If quick-relief medicine is needed more than 2 times a week, except before exercise, then call your doctor.**

EMERGENCY (Red Zone)

Your asthma is getting worse fast:
- Quick-relief medicine did not help within 15-20 minutes
- Breathing is hard or fast
- Nose opens wide • Ribs show
- Trouble walking and talking
- Lips blue • Fingernails blue
- Other:_____

And/or Peak flow below _____

Take these medicines NOW and CALL 911.
Asthma can be a life-threatening illness. Do not wait!

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	4 puffs every 20 minutes
☐ Xopenex®	4 puffs every 20 minutes
☐ Albuterol ☐ 1.25, ☐ 2.5 mg	1 unit nebulized every 20 minutes
☐ Duoneb®	1 unit nebulized every 20 minutes
☐ Xopenex® (Levalbuterol) ☐ 0.31, ☐ 0.63, ☐ 1.25 mg	1 unit nebulized every 20 minutes
☐ Combivent Respimat®	1 inhalation 4 times a day
☐ Other	

Triggers

Check all items that trigger patient's asthma:

- ☐ Colds/flu
- ☐ Exercise
- ☐ Allergens
  - ○ Dust Mites, dust, stuffed animals, carpet
  - ○ Pollen - trees, grass, weeds
  - ○ Mold
  - ○ Pets - animal dander
  - ○ Pests - rodents, cockroaches
- ☐ Odors (Irritants)
  - ○ Cigarette smoke & second hand smoke
  - ○ Perfumes, cleaning products, scented products
  - ○ Smoke from burning wood, inside or outside
- ☐ Weather
  - ○ Sudden temperature change
  - ○ Extreme weather - hot and cold
  - ○ Ozone alert days
- ☐ Foods:
  - ○ _____
  - ○ _____
  - ○ _____
- ☐ Other:
  - ○ _____
  - ○ _____
  - ○ _____

This asthma treatment plan is meant to assist, not replace, the clinical decision-making required to meet individual patient needs.

Permission to Self-administer Medication:

- ☐ This student is capable and has been instructed in the proper method of self-administering of the non-nebulized inhaled medications named above in accordance with NJ Law.
- ☐ This student is not approved to self-medicate.

PHYSICIAN/APN/PA SIGNATURE_____ DATE_____
Physician's Orders

PARENT/GUARDIAN SIGNATURE_____

PHYSICIAN STAMP

Save

Print

Print Medicines Only

REVISED AUGUST 2014

Make a copy for parent and for physician file, send original to school nurse or child care provider.

Asthma Treatment Plan – Student
Parent Instructions

The **PACNJ Asthma Treatment Plan** is designed to help everyone understand the steps necessary for the individual student to achieve the goal of controlled asthma.

1. **Parents/Guardians:** *Before taking this form to your Health Care Provider,* complete the top left section with:
   - Child's name
   - Child's date of birth
   - Child's doctor's name & phone number
   - An Emergency Contact person's name & phone number
   - Parent/Guardian's name & phone number

2. **Your Health Care Provider will** complete the following areas:
   - The effective date of this plan
   - The medicine information for the Healthy, Caution and Emergency sections
   - Your Health Care Provider will check the box next to the medication and check how much and how often to take it
   - Your Health Care Provider may check **"OTHER" and:**
     - ❖ **Write in asthma medications not listed on the form**
     - ❖ **Write in additional medications that will control your asthma**
     - ❖ **Write in generic medications in place of the name brand on the form**
   - Together you and your Health Care Provider will decide what asthma treatment is best for your child to follow

3. **Parents/Guardians & Health Care Providers together** will discuss and then complete the following areas:
   - Child's peak flow range in the Healthy, Caution and Emergency sections on the left side of the form
   - Child's asthma triggers on the right side of the form
   - Permission to Self-administer Medication section at the bottom of the form: Discuss your child's ability to self-administer the inhaled medications, check the appropriate box, and then both you and your Health Care Provider must sign and date the form

4. **Parents/Guardians:** *After completing the form with your Health Care Provider:*
   - Make copies of the Asthma Treatment Plan and give the signed original to your child's school nurse or child care provider
   - Keep a copy easily available at home to help manage your child's asthma
   - Give copies of the Asthma Treatment Plan to everyone who provides care for your child, for example: babysitters, before/after school program staff, coaches, scout leaders

PARENT AUTHORIZATION

I hereby give permission for my child to receive medication at school as prescribed in the Asthma Treatment Plan. Medication must be provided in its original prescription container properly labeled by a pharmacist or physician. I also give permission for the release and exchange of information between the school nurse and my child's health care provider concerning my child's health and medications. In addition, I understand that this information will be shared with school staff on a need to know basis.

Parent/Guardian Signature _____ Phone _____ Date _____

FILL OUT THE SECTION BELOW ONLY IF YOUR HEALTH CARE PROVIDER CHECKED PERMISSION FOR YOUR CHILD TO SELF-ADMINISTER ASTHMA MEDICATION ON THE FRONT OF THIS FORM.
RECOMMENDATIONS ARE EFFECTIVE FOR ONE (1) SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY

☐ I do request that my child be **ALLOWED** to carry the following medication _____ for self-administration in school pursuant to N.J.A.C.:6A:16-2.3. I give permission for my child to self-administer medication, as prescribed in this Asthma Treatment Plan for the current school year as I consider him/her to be responsible and capable of transporting, storing and self-administration of the medication. Medication must be kept in its original prescription container. I understand that the school district, agents and its employees shall incur no liability as a result of any condition or injury arising from the self-administration by the student of the medication prescribed on this form. I indemnify and hold harmless the School District, its agents and employees against any claims arising out of self-administration or lack of administration of this medication by the student.

☐ I **DO NOT** request that my child self-administer his/her asthma medication.

Parent/Guardian Signature _____ Phone _____ Date _____

The Pediatric/Adult Asthma Coalition of New Jersey
"Your Pathway to Asthma Control"
PACNJ approved Plan available at www.pacnj.org

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AMERICAN LUNG ASSOCIATION. IN NEW JERSEY

FORMS

Asthma

Medication Consent Forms

Food Allergy Forms

Epi-Pen Consent Forms

Seizure Forms

ALL FORMS CAN BE OBTAINED IN THE NURSES'S OFFICE OR NURSES'S CLASS PAGE

WWW.ERBOE.NET and click on School Nurse's Class Page

WHEN SHOULD A CHILD RETURN TO SCHOOL AFTER BEING SICK

Strep Throat- Students may return to school 24-48 hours after the first dose of antibiotics is given and as well as in accordance with your doctor.

Fever- Students may return to school when their temperature has been normal for 24 hours without taking any temperature lowering medications such as Tylenol, Motrin, and Advil...etc

Cold-Students should stay home if they are too uncomfortable to complete work. Students should also stay home if they have a persistent or severe cough and a runny nose with discharge. The student can return to school when their activity level has returned to normal.

Vomiting/Diarrhea- Students should be symptom free for 24 hours and be able to tolerate food and fluids before returning to school.

Skin Rashes- If the student exhibits a skin rash of undetermined origin; please consult your doctor before sending your child to school. A doctor's note stating the condition is not contagious is necessary for the student to return to school.

Conjunctivitis- If a student has been diagnosed as having conjunctivitis (pink eye), they may return to school with a doctor's note stating that they are being treated and are no longer contagious. No evidence of discharge from the eye should be present.

McKenzie School

125 Carlton Ave
East Rutherford, NJ 07073
Phone: Tel: 201-531-1235
Fax: 201-531-1491

School Nurses

Care For Kids

Nurse:
Joann Saab RN, MSN, APN, CSN

The State of New Jersey and the East Rutherford Board of Education requires that all students attending school must comply with immunization regulations and have a current entrance physical to attend school.

If your child's completed health record is not submitted by the first day of school he/she will not be permitted to start at that time.

Please notify the school nurse if there have been any changes to phone numbers and/or address changes.

Also, please keep a set of clean clothes in the classroom.

HEALTH CONCERNS

If your child has an injury at home or school requiring stitches, casts, crutches, splints/immobilizers, slings, etc. which also requires him/her to be excused from recess and/or physical education, please have the physician put this request in writing. Also, have him include the date when your child may return to normal activity. He/She may fax this to the school at (201)531-1491. A student may partake in physical education only if given permission in writing from an orthopedist, not a general physician after they are healed from their injury. If your child needs to use the school elevator, this must also be stated in writing by the treating physician.

During the winter months, influenza, strep throat, stomach viruses, common cold, etc. become more prevalent. If your child has come in contact with another child who has symptoms of the above, watch him/her for a few days to monitor if he/she is beginning to have symptoms. If your child has fever of 100.0 or above, nausea, vomiting, sore throat more than expected with a common cold, please keep your child home from school until he/she has been major symptom/fever free for 24 hours. Contact the pediatrician if symptoms persist or worsen. If he/she returns to school before symptoms have ceased, there is the possibility of transmitting the germs to other students and staff and the cycle of illness will repeat. Let's work together to prevent (as much to our ability) more sickness and absences. We all want a healthy environment for the children to learn in!

MEDICATION IN SCHOOL

New Jersey State law PROHIBITS administration of ANY medication, including Tylenol, Advil, or any other "over - the- counter" medication without a doctor's order and a parent's or guardian note.

- All OVER THE COUNTER medications MUST be supplied from home, and labeled with the student's name.

- ANY Medication administered in school MUST be in its original container, and labeled with the student's name.

- A fax will be accepted from the prescribing physician, and parent or guardian, if your child needs to take medication in school. It is the parent's responsibility to call the doctor to request a medication order.

- Any medication that is a "controlled substance" (ex. Ritalin, Adderall, Concerta) MUST be brought in by a parent or guardian. Any "controlled substance" brought in by a student will not be administered. The number of pills must be verified with the school nurse.

MEDICATION SENT TO SCHOOL IN A BAGGIE, ENVELOPE OR TISSUE WILL NOT BE ADMINISTERED

Students with asthma may carry their inhalers with them only with physician authorization. Your physician may write on a prescription or a office letter stating that your child is responsible, has been instructed in the proper use of the inhaler and may carry his/her inhaler with him/her at all times. This note/letter must be on file in the nurse's office.