Township of Union Public Schools
2369 Morris Ave, Union, NJ 07083

New Student Registration Medical Packet

If you are registering a new student, you must provide the following:

1. **Immunization record**: proof of required immunizations in the form of a school record, or a public health record. The record must be legible and translated into English.

2. **Physical Exam:** All students must submit a physical examination within 30 days of their start date. A physical examination form is included in this packet.

3. **Mantoux Test:** If the student is entering from outside of the United States, they may need proof of a Mantoux test done within the past six months. The school nurse will make you aware.

4. **Health History:** Please fill out both pages of the attached health history

For information regarding free or reduced fee health information please go to:
www.njfamilycare.org
www.findahealthcenter.hrsa.gov

TOWNSHIP OF UNION PUBLIC SCHOOLS

Linda M. Ionta, Director
Athletics, Health, Physical Education & Nurses

NEW JERSEY DEPARTMENT OF EDUCATION - IMMUNIZATION GUIDELINES

DTP (Diphtheria, Tetanus, Toxoid and Pertussis
- Ages 1-6 years - 4 doses with 1 does given *on/or* after the 4th birthday, or any 5 doses
- Ages 7 or Older - 3 doses of TD or a combination of DTP, DtaP, and Td

Tdap Booster
- Students born *on/or* after 1/1/97 attending or transferring into New Jersey school at Grades 6 or higher.

Poliovirus Vaccine
- Ages 1-6 years - 3 doses with one dose given on/or after the 4th birthday, or any 4 doses
- Ages 7-17 years - 3 doses either OPV or IPV separately or in combination

Measles
- 2 doses of measles containing vaccine.
- 1st dose given *on/or* after the 1st birthday (If before 1st birthday, re-immunization is required.)
- Intervals between 1st and 2nd measles/MMR cannot be less than 1 month. Laboratory evidence of immunity is also acceptable.

Rubella
- 1 dose or laboratory evidence of immunity. First dose given *on/or* after the 1st birthday. (If before 1st birthday, re-immunization is required.)

Mumps
- 1 dose or laboratory evidence of immunity. First dose given *on/or* after the 1st birthday. (If before 1st birthday, re-immunization is required.)

Hepatitis B Virus Vaccine
- Ages 1-15 - 3 doses or 2 doses Adult formulation (ages 11-15) or laboratory evidence of immunity.

Varicella (Chicken Pox) Vaccine
- 1 dose given *on/or* after 1st birthday or documented proof of disease by a parent/guardian or physician statement or laboratory evidence of immunity.

Meningococcal Vaccine
- Grades 6-12 - Students born *on/or* after 1/1/97 attending or transferring into New Jersey school at grade 6 or higher.

Mantoux Test (PPD)
- Students entering a United States school for the 1st time in New Jersey or transferring into a New Jersey school ***from any country not listed below must receive*** an IGRA or Mantoux Tuberculin Skin Test:

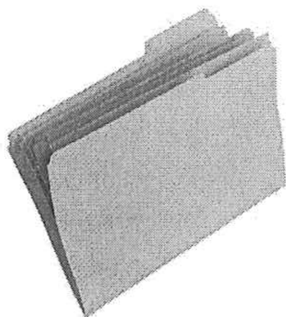
Antigua
Australia
Austria
Barbados
Barbuda
Belgium
Bermuda
Canada
Cayman Islands
Cuba
Cyprus
Czech Republic
Denmark
Finland
France
Germany
Greenland
Grenada
Iceland
Ireland
Israel
Italy
Jamaica
Jordan
Lebanon
Luxembourg
Malta
Monaco
Montserrat
Netherlands
Netherlands Antilles
New Zealand
Norway
Oman
Puerto Rico
Saint Kitts and Nevis
San Marino
Sweden
Switzerland
Trinidad
Tobago
United Kingdom of Great Britain and Northern Ireland
United States of America
United Virgin Islands

TOWNSHIP OF UNION PUBLIC SCHOOLS
Linda M. Ionta, Director
Athletics, Health, Physical Education & Nurses

REQUEST FOR HEALTH RECORDS

Date ______________________

Student's Name: ____



Date of Birth: ______________________________ Grade: ____________

Name of previous school: ____

Address of previous school: ______________________________________

City: ___________________________ State: _________ Zip Code: _________

Please send the original A-45 and other pertinent health information to:

☐ Burnet Middle School
Health Office
1000 Caldwell Avenue
Union, NJ 07083
#908-851-6498

☐ Kawameeh Middle School
Health Office
490 David Terrace
Union, NJ 07083
#908-851-6579

☐ Union High School
Health Office
2350 N. Third Street
Union, NJ 07083
#908-851-6550

☐ Battle Hill Elementary
Health Office
2600 Killian Place
Union, NJ 07083
#908-851-6488

☐ Connecticut Farms Elementary
Health Office
875 Stuyvesant Avenue
Union, NJ 07083
#908-851-6477

☐ Franklin Elementary
Health Office
1550 Lindy Terrace
Union, NJ 07083
#908-851-6455

☐ Hannah Caldwell Elementary
Health Office
1120 Commerce Avenue
Union, NJ 07083
#908-206-6104

☐ Jefferson Elementary
Health Office
155 Hilton Avenue
Vauxhall, NJ 07088
#908-851-6566

☐ Livingston Elementary
Health Office
960 Midland Blvd.
Union, NJ 07083
#908-851-6444

☐ Washington Elementary
Health Office
301Washington Avenue
Union, NJ 07083
#908-851-6466

Please send to appropriate school. Thank you for your anticipated cooperation!

Township of Union Public Schools

Linda M. Ionta, Director
Athletics, Health/Physical Education/Nurses

Dear Parent/Guardian:

New Jersey State Legislature mandates that students between the ages of 10 and 18 (Grades 5, 7, 9 and 11) shall receive a school examination every other year for scoliosis (a curvature of the spine).

The purpose of this program is to recognize the problem at its earliest stages so that the need for treatment can be determined.

If further consultation is recommended, parents/guardians of students who are found to have signs of a possible spinal abnormality will be notified and will be asked to see their own physician for further evaluation.

If your child is currently under active treatment for a spinal problem or you would rather not have your child screened, please return the bottom portion of this letter to the Nurse's Office.

This ***will be the only notification*** you will receive while your child is in the Township of Union Public Schools.

Sincerely,

Linda Ionta, Director
Athletics, Health, Physical Education & Nurses

PLEASE RETURN WITHIN ONE WEEK TO THE SCHOOL NURSE

__________________________________ ________ ________
Child's Name Grade Homeroom

☐ I do not wish my child screened for spinal curvature.

☐ My child is currently under care for a spinal problem with Dr.______________________________.

☐ I wish my child screened for spinal curvature.

______________________________ __________
Parent/Guardian Signature Date

UNION TOWNSHIP PUBLIC SCHOOLS
UNION, NEW JERSEY 07083

STUDENT HEALTH HISTORY

Student's Name: ____

Date of Birth: ____________________

Birthplace: ______________________

Where did the student reside before entering this school? ____________________
(city/state)

____
(country)

	YES	NO
Is this the first time this student will attend school in the United States?	____	____
Has anyone in student's close family ever had		
Diabetes (high sugar in blood) ?	____	____
Allergies (hay fever or asthma)?	____	____
Migraine headaches?	____	____
Heart trouble?	____	____
High blood pressure?	____	____
Sudden death?	____	____
Has student had or does student have		
Tendency to lose consciousness (faint) ?	____	____
Convulsions or epilepsy?	____	____
Heart trouble?	____	____
High blood pressure?	____	____
Persistent cough?	____	____
Chest pain with exercise?	____	____
Dizziness or faintness with exercise?	____	____
Has student had or does student have		
Very bad (impaired) vision in one eye?	____	____
Temporary loss of vision?	____	____
To wear glasses or contact lenses?	____	____

	YES	NO
Has student had or does student have		
Hearing loss?	____	____
Perforated ear drum?	____	____
Sinus infection?	____	____
Broken nose?	____	____
Orthodontia (teeth straightened)?	____	____
Has student had or does student have		
Kidney problems?	____	____
(Boys) Loss of function or absence of testicles?	____	____
(Girls) Menstrual problems?	____	____
Age of onset of menstruation_______________		
Has student had or does student have		
Asthma (wheezing)?	____	____
Hay fever?	____	____
Hives or rash?	____	____
Bee sting reactions (allergy)?	____	____
Reaction to medicine (allergy)?	____	____
Has student or does student		
Smoke?		
Take any medicine regularly?	____	____
If yes, name_________________________		
Take medicine for emergency use?	____	____
If yes, name_________________________		
Has student or does student have any injury?	____	____
Has student had or does student have		
Tendency to bleed or bruise easily?	____	____
Anemia ("tired" blood)?	____	____
Weight problem (under or overweight)?	____	____
Has student had or does student have a skin condition?	____	____
If yes, name_______________________________		
Has student ever been told to give up sports because of health problems?	____	____

Additional information concerning "YES" checked above:_________________________

____

Parent/Guardian Signature: Date: ______________________________

TOWNSHIP OF UNION PUBLIC SCHOOLS
PROCEDURES REGARDING ADMINISTRATION OF MEDICATION IN SCHOOL

The administration of prescribed medication to a student during school hours will be permitted only when failure to take such medicine would jeopardize the health of the student, and the student would not be able to attend school if the medicine were not made available during school hours.

1. The school does not provide medication to students.
2. The parent/guardian or parent designee must bring in all medication.
3. The parent/guardian must provide a written request for the administration of the prescribed medication in school. (Signed Medication Authorization Form.)
4. *Non-prescription medication*: Written orders are to be provided to the school by the Primary Physician, detailing the name of the student, name of the drug, dosage, and time of administration. All non-prescription medication must be brought to school in the original container. (Signed Medication Authorization Form.) It is recommended that medications be given between 11:30 a.m. and 12:30 p.m., in order to maintain the continuity of the student's learning process.
5. *Prescription medication*: Written orders are to be provided to the school by the Primary Physician, detailing the name of student, name of the drug, diagnosis and the reason for administration of the drug, dosage, and time of administration. Must be brought to school in the original container with a ***current date***, appropriately labeled by the pharmacy or physician indicating the student's name, name of medication, diagnosis and reason for administration of the medication, dosage time of administration. (Signed Medication Authorization Form.) It is recommended that medications be given between 11:30 a.m. and 12:30 p.m., in order to maintain continuity of the student's learning process.
6. The school will provide safe storage of the medication.
7. The records or documentation process is required to be maintained by the certified school nurse.
8. The certified school nurse or parent/guardian is the only one permitted to administer medication in the school or on school trips.

CONSIDERATION FOR FIELD TRIPS

Children who require daily medication will need special consideration when planning school trips. The following is a list of appropriate options. Of course, each of these would require approval of the child's parent/guardian and physician. They include:

A. Altering the scheduled hours of administering the medication so the child is getting the first dose at school (about 9:00 a.m.) and the second dose after the class returns (usually about 2:00 p.m.).
B. Withholding medication during the course of that particular activity and giving it when the student returns to school.
C. Requesting that a parent/guardian of the affected child accompany the group to administer the medication to the child.

Linda Ionta, Supervisor
Health and Medical Services

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

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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