CAPE MAY COUNTY TECHNICAL HIGH SCHOOL
188 Crest Haven Road
Cape May Court House, NJ 08210

School Nurse Office
(609) 380-0200 ext. 658

Dear Parents/Guardians of returning students in grades 10, 11 & 12 enrolled in Full-Day High School,

To prepare for the next new school term please complete the appropriate documents. Return the forms to the school nurse as soon as possible.

REQUIRED FORM for all returning students:

- **Annual Health Update.** A parent/guardian may fill out this form; you do not need to have a physician complete it. The "Annual Health Update" form provides vital health information regarding your child and is required annually to be part of your child's school health record. The form allows the school nurse to contact the person(s) you designate as emergency contacts and, if needed, to provide information to Emergency Medical Personnel.

OPTIONAL *forms:*

- **Medication Policy and order forms**:
  You and your child's physician must complete our form if your child requires medication to be administered in school. Forms are available through our website:
  https://capemaytech.com/hs-medication-forms.html
  If you do not have access to a computer/printer, call the School Nurse 380-0200 ext. 658, and leave a message for forms to be mailed to you (please leave your child's name and date of birth).

- **Sport Physicals:**
  These forms are **required annually for sports participation** and are also valid for working papers. Forms are available through our website:
  https://capemaytech.com/SportsPhysical.pdf
  If you do not have access to a computer/printer contact the High School Office: 380-0200 and ask for the "sport physical packet".

Reminder: Health screenings, for students who do not have a yearly physical on file, are conducted by the school nurse and may include height, weight, scoliosis, hearing, vision or blood pressure testing. If you do not wish the school to conduct the required health screenings you must notify the school nurse in writing.

Enclosures: Annual Health Update

LZ: Word misc/Returning Students Annual Health Requirements 2021

Cape May County Technical High School: Annual Health Update for Returning Students Enrolled Full Day: 20__-20___

Student Name (print):_____ Grade:_____ D.O.B.___/___/___

Student's Physician:_____Telephone:_____ Dentist:_____Telephone: _____

My child has medical health insurance: Name of insurance company:_____

NO, my child does not have medical health insurance. NJ FamilyCare provides free or low cost health insurance: call 800-701-0710 or visit www.njfamilycare.org. Release my name and address to NJFamilyCare Program to contact me about health insurance for my child. Signature: _____*Written consent required pursuant to 20U.S.C. & 1232g (b)(1) and 34 C.*

Check health conditions your child has. Only pertinent health information is shared with staff on a "need to know basis".

- ☐ Allergy to Medication(s): list _____
- ☐ Latex allergy (medical gloves, tapes, etc): If exposed, does your child require emergency epinephrine? NO YES *
- ☐ Food allergy - List foods allergic to:_____
  If exposed to food allergy, does your child require emergency epinephrine medication? NO YES *
- ☐ Insect allergy - List insects allergic to: _____
  If stung/bitten by insect, does your child require emergency epinephrine injection? NO YES *

If "YES" provide the school nurse with an annually updated "Life-threatening Allergy Medical Plan".

- ☐ Diabetes: Type: 1 OR 2. ***Provide school nurse with annually updated "Diabetic Health Care/Medical Plan".***
- ☐ Seizure Disorder: Type of seizure: _____ Date of last seizure: _____
  If YES, provide the school nurse with an annually updated "Seizure Health Care Plan".
- ☐ Asthma: Carries inhaler in school and/or sports? NO **YES** If "yes," name of inhaler: _____
  If "YES", ***provide the school nurse with an annually updated "Asthma Action Plan".***
- ☐ Bleeding disorder: name/type of disorder:_____
- ☐ ADHD/ADD: Medication:_____ If administered at school call nurse for medication forms.
- ☐ Migraine headaches evaluated by a physician. Medication:_____
- ☐ Vision: ☐glasses ☐contacts ☐color deficiency ☐Nystagmus ☐Low vision, blindness, etc: Type:_____
- ☐ Hearing difficulty: which ear: ___Right ___Left ___Both Hearing aids worn? NO YES
- ☐ Mental/emotional health diagnosis:_____ Share information with teachers? YES NO
- ☐ Hospitalizations, surgeries, injuries or illnesses the **past 12 months**. Explain: _____
- ☐ Other problem(s) not listed above. Explain: _____
- ☐ Other medications taken not listed above: _____

In the event of a medical emergency your child will be transported to the nearest hospital emergency room. Indicate your contact information, and anyone else you want us to contact, in the event you cannot be reached.

#1 Parent/Guardian Name: _____ Home: _____ Work: _____ Cell:_____

#2 Contact Name: _____ Relationship: _____ Home: _____ Work: _____ Cell:_____

#3 Contact Name: _____ Relationship: _____ Home: _____ Work: _____ Cell:_____

Indicate name(s) of the parent(s) or guardian(s) child lives with: Name(s): _____

Address: _____
Street Town/City Zip code

Mailing address (if different from above):_____

I give permission for the school nurse to administer ,as indicated and outlined, by the school physician: (cross off items you do not want your child to receive): acetaminophen or ibuprofen, throat lozenges, topical antibiotic ointments and antiseptics, calamine lotion, hydrocortisone crème, oragel/ambesol, blister care 2nd skin, foille/watergel for burns.

Parent/guardian signature:_____ Date:_____