CAPE MAY COUNTY TECHNICAL HIGH SCHOOL
188 Crest Haven Road
Cape May Court House, NJ 08210
School Nurse: (609) 380-0200 ext. 658

For School Year 2020-21

Dear Parents/Guardians of returning students grade 10, 11, &12 Partial Day Career/Technical Programs,

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.
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OPTIONAL forms:

- **Medication Policy and order forms**: You and your child's physician must complete a medication order form if your child requires medication to be administered in school. You can access a form through our website:
  https://capemaytech.com/hs-medication-forms.html
  If you do not have access to a computer/printer, call the School Nurse 465-2161 ext. 658, and leave a message for forms to be mailed to you (please leave your child's name and date of birth).

Helpful Hint: If you use forms from your child's sending school you may copy those forms for the Cape May County Technical School Nurse. It is not necessary to have the physician complete two separate forms.

- **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".

Please return these forms as soon as possible to the school nurse.

Sincerely,
Lynda Zipparo, RN, BSN
School Nurse

Enclosures: Annual Health Update

Cape May County Technical High School: Annual Health Update for Students Enrolled Half Day : 2020-21

Student Name (print):_____Grade:____ D.O.B.___/___/___ Name of home school:_____
Student's Physician:_____ Telephone:_____
Student's Dentist:_____ Telephone:_____
Health Insurance: YES NO If yes, name of insurance:_____
Date of your child's last tetanus (Td or Tdap) booster: ____/____/____

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 all school nurses with an annually updated "Life-threatening Allergy Medical Plan".

- ☐ Diabetes: Type: 1 OR 2. ***Provide all school nurses with annual "Diabetic Health Care/Medical Plan".***
- ☐ Seizure Disorder: Type of seizure: _____ Date of last seizure: _____
  If YES, Provide all school nurses with the annually updated "Seizure Health Care Plan".
- ☐ Asthma: Carries inhaler in school and/or sports? NO **YES** If "yes," name of inhaler: _____
  If "YES" ***provide all school nurses with the 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: _____
- ☐ Medication(s) taken (indicate name of medications, doses and times taken): _____

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:_____ 2020