Sick Day Guidelines:

Making the Right Call When Your Child Is Sick:

***Should I keep my child home or send him/her to school?***

School policy (and/or state law) requires a child stay home if he/she:

- Has a fever of **100** degrees or higher
- Has been vomiting or has diarrhea
- Has symptoms that keep you child from participating in school, such as:
  Very tired or lack of appetite
  Cough that he/she cannot control, sneezing often
  Headache, body aches or earaches
  Sore throat- a little sore throat is ok for school, but a bad sore throat could be **strep throat**, even if there is no fever. Other signs of strep throat in children are headache and stomach upset, or rash. Call your doctor if your child has these signs. A special test is needed to know if it is strep throat.

Keep your child home if he/she is coughing or sneezing often because this spreads sickness to others.

***24 HOUR RULE:***

- **FEVER:** Keep your child home until his/her **FEVER** has been gone **WITHOUT** medication for **24 HOURS**. Colds can be contagious for at least 48 hours. Returning to school too soon may slow recovery and make others sick.

- **VOMITING OR DIARRHEA:** Keep your child home for **24 HOURS** after the **LAST** time he/she vomited or had diarrhea. **The child must be able to eat a regular meal.**

- **ANTIBIOTICS:** Keep your child home until **24 HOURS** after the **FIRST** dose of antibiotics for anything like ear infections or strep throat.

We often have many children and adults with colds coming into the school, and each one is passing their sickness to others. Please help others from becoming sick by keeping your child home while the sickest.

For more information, or if you have any questions, please contact the School Nurse:
Mrs. Roa (201) 974-2053 ext 2056

**IF YOUR CHILD IS ABSENT FOR MORE THAN 3 DAYS, A NOTE FROM YOUR HEALTHCARE PROVIDER IS NEEDED FOR YOUR CHILD TO RETURN TO SCHOOL.**

Huber Street School
1520 Paterson Plank Road
Secaucus, NJ 07094
Office of the School Nurse
Allison Roa, RN, CSN
Phone (201)-974-2056
Fax (201)-974-1950

STUDENT_____ DATE_____

DATE OF BIRTH_____ GRADE_____

As a 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 amongst appropriate professional staff involved in the care of the above named student. This consent is valid in the Secaucus School system and is intended to allow the staff to better serve your child.

Sincerely,

Allison Roa, RN

_____
Signature of Parent/Guardian

_____
Date

**HUBER STREET SCHOOL**
**1520 PATERSON PLANK ROAD**
**SECAUCUS, NJ 07094**

Dear Parent or Guardian:

Welcome to a new school year! Recent studies have shown that asthma and other allergies are on the rise in school- aged children. In order to help meet your child's health needs, please complete the questionnaire below and return it by the first week of school.

Allison Roa
School Nurse

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NAME_____GRADE_____

TEACHER_____

Does your child have asthma?_____yes_____no

Does your child take asthma medication at home?_____yes_____no
Name of medication_____

Does your child need to take asthma medication at school?_____yes_____no
Name of medication_____

Do you have an Asthma Action Plan in place with your child's physician?_____yes_____no

Does your child have any food allergies?_____yes_____no
List the foods_____

Does your child have any other allergies (any medications, hay fever etc.)____yes_____no
List the allergies_____

Does your child take any medication for his/her allergies?_____yes_____no
Name of medication_____

Does your child need to take this medication in school? (Non-emergency medication) ___yes___no

Does your child need to have emergency medication to be kept in school for a severe allergic reaction to his/her known allergy?_____yes_____no
Name of medication_____

DATE_____PARENT SIGNATURE_____

Public School District

# SecaucuS

20 Centre Avenue | Secaucus, New Jersey | 07094

## STUDENT MEDICATION FORM (Only complete if medication is needed for school)

**STUDENT INFORMATION**

Student Name: _____ Birthdate: _____

School: _____ Grade: _____

Parent/Guardian Name: _____

Parent/Guardian Phone: (home) _____ (work) _____ (cell) _____

**MEDICAL PROVIDER INFORMATION**

Licensed Medical Provider: _____

Address: _____

Phone: _____ Fax: _____

Physician's Stamp

**MEDICATION INFORMATION TO BE COMPLETED BY PHYSICIAN**

DOCTOR'S REQUEST/INSTRUCTIONS FOR STUDENT Start Date: _____

**ADMINISTRATION OF MEDICATION BY SCHOOL NURSE**

The medication listed below is **TO** be administered to my patient _____

Medication: _____ Dose & Route/Time: _____

Diagnosis: _____ Treatment to be Continued Until: _____

Significant Side Effects: _____

_____ _____ _____

Physician's Signature Physician's Name Date

**SELF ADMINISTRATION OF MEDICATIONS FOR POTENTIALLY LIFE THREATENING ILLNESS**

The medication listed below is to be administered **BY** my patient _____

I hearby certify that my patient has a life threatening illness and that my patient is capable of and have been instructed in the proper administration of the required medication.

Medication: _____ Dose & Route/Time: _____

_____ _____ _____

Physician's Signature Physician's Name Date

**PARENT REQUEST AND RELEASE TO BE COMPLETED BY PARENT/GUARDIAN**

I request my child _____ to receive/self administer the medication designated above. I have been informed by the school district, its agents, servants and employees shall incur no liability whatsoever as a result of any untoward reaction arising from the administration of medicine by my child. I hereby indemnify and hold harmless the Secaucus Board of Education, its agents, servants and employees from any and all claims and shall defend any lawsuit that may arise out of or in connection with the administration of medication by my child.

_____ _____ _____

Parent/Guardian Signature Parent/Guardian Name Date

**Secaucus Schools**
**Student Personal Health History**
***Please Complete Both Sides!!!***

Student's Name:_____ Date:_____

Date of Birth:_____ Place of Birth:_____

Birth Weight:_____pounds _____ounces

Illness of Mother During Pregnancy: Yes____ No____
If Yes, please explain_____

Complications of Delivery: Yes____ No____
If Yes, please explain_____

Difficulty Soon After Birth: Yes____ No ____
If Yes, please explain_____

| HAS CHILD HAD... | YES | DATE | NO |
|---|---|---|---|
| Measles | | | |
| Mumps | | | |
| Rubella | | | |
| Chicken Pox | | | |
| Rheumatic Fever | | | |
| Asthma | | | |
| Pneumonia | | | |
| Frequent Sore Throats | | | |
| Frequent Ear Infections | | | |
| Trouble with Hearing | | | |
| Trouble with Speech | | | |
| Trouble with Vision | | | |
| Frequent Vomiting and/or Diarrhea | | | |
| Tendency to Bleed Easily | | | |
| Eczema or Hives | | | |
| Convulsions or other Seizures (explain on back) | | | |
| Difficulty with Toilet Training or Bed Wetting | | | |
| Any Severe Injuries (explain on back) | | | |
| Any Operations (explain on back) | | | |
| History of Heart Murmur | | | |
| Other Medical Conditions (explain on back) | | | |

# SECAUCUS PUBLIC SCHOOLS
## ENTRANCE PHYSICAL EXAMINATION

Name_____ Exam Date_____ Age_____ Date of Birth_____

Address_____ City/State/Zip_____ Home Phone_____

School_____ Sport_____ Grade_____ Sex_____

Physician_____ Phone_____ Fax_____

Address_____ City/State/Zip_____

**PHYSICIAN OR PROVIDER INFORMATION - PLEASE COMPLETE**

Height_____ Weight_____ Blood Pressure_____ Pulse_____bpm

Vision: R - 20/_____ L - 20/___ Corrected - Y / N Contacts - Y / N Glasses - Y / N Hearing: R_____ L_____

| | NORMAL | ABNORMAL FINDINGS | COMMENTS |
|---|---|---|---|
| Head/Neck | | | |
| Eyes/Sclera/Pupils | | | |
| Ears | | | |
| Neck/Mouth/Throat | | | |
| Heart: Murmurs/Rhythms | | | |
| Lungs: Auscultation/Percussion | | | |
| Chest Contour | | | |
| Skin | | | |
| Abdomen: Assessment (include Live, Spleen) | | | |
| Tanner Stage: Testes/Onset of Menses | | | |
| Hernia | NO | YES/POSSIBLE | |
| Neck/Back/Spine: Range of Motion | | | |
| Scoliosis | | | |
| Upper Extremities | | | |
| Lower Extremities | | | |
| Neurological: | | | |
| Balance & Coordination | | | |
| Romberg | | | |
| Heel Walk | | | |
| Tandem Walk | | | |
| Nose Touch | | | |
| Toe Walk | | | |
| Most Recent Immunization/Dates | | | |
| Medications Currently in Use | | | |
| Additonal Observations | | | |

Student may participate in all school activities including gym and recess Yes_____ No_____

If no, please explain_____

EXAMINED BY: Physician's/Provider's Stamp:

Family Physician/Provider_____

School Physician_____

_____MD _____DO _____NP _____PA

Physician's/Provider's Signature_____