



### 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

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 \_\_\_\_\_

**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 &amp; 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 hereby 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 &amp; 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			
Additional 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 \_\_\_\_\_