SPOTSWOOD MEMORIAL SCHOOL

GRAHAM PEABODY
ACTING SUPERINTENDENT

115 SUMMERHILL ROAD • SPOTSWOOD, NEW JERSEY 08884
732-723-2200 • FAX: 732-251-7666
WEBSITE: WWW.SPSD.US

BRIAN KITCHIN
PRINCIPAL
BKITCHIN@SPSD.US

Dear Parents/Guardians,

As we look forward to the coming 2018-2019 school year, please take a moment to review the forms required for your child to participate accordingly.

UNIVERSAL CHILD HEALTH RECORDS

The Spotswood Board of Education requires periodic examinations for their students in order to insure that the learning potential of each student is not diminished by a remedial physical disability, the student is able to participate in the school program, and that the community is protected from the spread of communicable disease. Physical exams must be completed by your child's pediatrician and the doctor must complete a Universal Child Health Record (attached). Please submit all completed Universal Child Health Records to Memorial Middle School prior to the 2018-2019 school year.

Universal Child Health Records are Required for the following students:

- ALL students entering 6th Grade
- ALL students entering 8th Grade
- ALL students who are new to the district

ATHLETIC FORMS

Any student wishing to participate in a sport within the coming school year must submit an Athletic Physical including ALL four of the components below. The forms are available on the district website at www.spsd.us under the "Athletics and Extracurricular" tab and must be submitted by deadlines announced for the given sports season. Please check the district website carefully for updates as athletic seasons approach.

Parents Guardians

All forms below are to be completed

1. Preparticipation Physical Evaluation Form - Parents must complete and sign. (These forms must be re-submitted for **each sport** during the school year.)
2. Physical Examination and Clearance Forms - Your child's pediatrician must complete, sign, and stamp. The physical is effective for one year from the date of the examination. The district physician, Dr. Speesler, will review all physicals once they are completed entirely by your child's pediatrician.
3. Concussion Form (required for each season during the school year)
4. Cardiac Sign-off Sheet (required for each season during the school year)

District Physician Dr. Speesler is located at 150 Tices Lane #A, East Brunswick, NJ 08816 Phone: 732-254-5553

Thank you for your assistance, and please do not hesitate the contact me if you have any questions or concerns.

Sincerely,

Katherine Shkolar, RN BSN NJ-CSN
Memorial Middle School Nurse - 732-723-2200 ext. 2050
kshkolar@spsd.us

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Dear Parents/Guardians:

This is to inform you that the New Jersey Department of Health and Senior Services (DHSS) have recently revised the administrative rules with substantive changes to include the requirement of new vaccines for students attending sixth grade in September, 2018. The amended regulations state the following:

Every child born on or after January 1, 1997 and entering grade six on or after September 1, 2008 shall have received one (1) dose of Tdap (Tetanus, diphtheria, acellular pertussis) given no earlier than the 10th birthday.

Children entering or attending grade six on or after September 1, 2008 who received a Td booster dose less than five (5) years prior to entry or attendance shall not be required to receive a Tdap dose until five (5) years have elapsed from the last DTP/Dtap or Td dose.

Every child born on or after January 1, 2007 and entering or attending grade six on or after September 1, 2008 shall have received one (1) dose of a meningococcal-containing vaccine, such as the medically-preferred meningococcal conjugate vaccine.

Students must provide documentation of these immunizations from their Primary Care Provider by the beginning of school, September 2018. We are requesting that your Primary Care Provider complete the form below and return to Memorial School, 115 Summerhill Road, Spotswood NJ 08884, attention Katherine Shkolar RN prior to the start of the 2018 -2019 school year. Thank you for your cooperation in this matter.

Sincerely,

Katherine Shkolar RN

Katherine Shkolar RN BSN NJ-CSN Memorial Middle School 732-723-2200 ext. 2050
kshkolar@spsd.us

Student's Name: ______________________________ Date: ______________

Age: ________

The above-named student has received:

1. The Tdap booster on: ______________________________
   Month/Day/Year

2. The Meningococcal vaccine on: ______________________________
   Month/Day/Year

____
Signature of Primary Care Provider

____
Print of Stamp of Primary Care Provider

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: *American Academy of Pediatrics, New Jersey Chapter*
New Jersey Academy of Family Physicians
New Jersey Department of Health

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name *(Last)*	*(First)*	Gender ☐ Male ☐ Female	Date of Birth / /

Does Child Have Health Insurance? ☐Yes ☐No	If Yes, Name of Child's Health Insurance Carrier

Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number
Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number

I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Signature/Date	This form may be released to WIC. ☐Yes ☐No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:	Results of physical examination normal? ☐Yes ☐No

Abnormalities Noted:		
	Weight *(must be taken within 30 days for WIC)*	
	Height *(must be taken within 30 days for WIC)*	
	Head Circumference *(if <2 Years)*	
	Blood Pressure *(if ≥3 Years)*	

IMMUNIZATIONS	☐ Immunization Record Attached ☐ Date Next Immunization Due:

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐ None ☐ Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	☐ None ☐ Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☐ None ☐ Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐ None ☐ Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☐ None ☐ Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☐ None ☐ Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☐ None ☐ Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: ☐ Capillary ☐ Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

☐ ***I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.***

Name of Health Care Provider (Print)	Health Care Provider Stamp
Signature/Date	

Distribution: Original-Child Care Provider Copy-Parent/Guardian Copy-Health Care Provider