



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. Impreveduto (201) 624-2657

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.

SECAUCUS PUBLIC SCHOOLS

HEALTH OFFICE

**PRE-KINDERGARTEN
REQUIRED ANNUAL INFLUENZA VACCINE**

DUE BETWEEN SEPTEMBER 1ST AND DECEMBER 31ST

NAME: _____ **HOMEROOM** _____

INFLUENZA VACCINE DATE: _____

PHYSICIAN'S/PROVIDER'S NAME _____

PHYSICIAN'S/PROVIDER'S SIGNATURE _____



PHYSICIANS STAMP

SECAUCUS PUBLIC SCHOOLS

SECAUCUS EARLY LEARNING CENTER

40 MILLRIDGE ROAD

Secaucus, N.J. 07094

Office of the School Nurse

Margaret Impeveduto, RN,BSN,CSN

Phone# 201-624-2657

Fax# 201-624-0371

STUDENT _____ **DATE** _____

DATE OF BIRTH _____ **GRADE** _____

As 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,

Margaret Impeveduto, RN,BSN,CSN
School Nurse

Signature of Parent or Guardian

Date

**SECAUCUS EARLY LEARNING CENTER
40 MILLRIDGE 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.

Margaret Impreveduto
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 & 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 & 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 _____