LOWER CAPE MAY REGIONAL HIGH SCHOOL
687 ROUTE 9 - CAPE MAY, NJ 08204
(609) 884-3475

Dear Parent/Guardian:

Welcome to the new school year! Hopefully it will be a healthy one for you and your child.

Medication Policy:

1. It is recommend if your child needs to take daily prescribed medication, **please administer it at home when possible**. If he/she needs to take prescribed medication in school you will need to do the following:

- A prescription from your doctor stating the medication name, dose and time it needs to be administered. (On a prescription pad)
- Medication needs to be in a labeled prescription bottle. (from the pharmacy)
- A parent signature on the permission form to administer the medication in school (which is in this packet, and can also be found on our website **lcmrschooldistrict.com**)

2. For over the counter medication such as acetaminophen, ibuprofen, Advil, antacids, ect. a parent signature on the OTC medication form must be sent in along with the OTC medication provided by the parent. The medication will be kept in the nurse's office.

ABSOLUTELY NO MEDICATION WILL BE GIVEN WITHOUT WRITTEN PERMISSION.

Gym Excuse Policy: You must supply a physician's note stating length of exclusion, reason for exclusion and day Physical Education may be resumed.

Emergency Contacts: Please make arrangements to have someone we can reach in case of an emergency or you are unavailable to be reached. Please return the enclosed emergency contact information form to the nurse office. If a child needs to go home sick, the nurse will call you personally.

Immunizations: Please send in a written confirmation when your child receives a vaccination so we can keep the health card up to date.

Student Accident Insurance: If you wish to purchase affordable 24-Hour coverage of student accident insurance (With or Without a Dental Benefit), the application forms are available in the nurses office.

Thank You for your cooperation. Any questions please contact me at 884-3475 ext 238

School Nurse

PLEASE NOTE: If your child is absent, please call the **SCHOOL ATTENDANCE OFFICER** (Ext. 268) between 7:30 A.M. and 9:00 A.M. to verify the absence.

RETURN TO NURSE'S OFFICE

LOWER CAPE MAY REGIONAL SCHOOL DISTRICT

Request for Over The Counter Medication to be given at school

I request the nurse to see that_____Grade___ ID#_____

receives the following medication _____
(Acetaminophen, Ibuprofen, Antacid, etc.)

for _____ as needed for the_____school year.
(Headaches, Cramps, etc.)

The medication is **TO BE FURNISHED BY ME** in the original container with the **ORIGINAL STORE OR PHARMACY LABEL INTACT**. **All medication MUST be kept in the Nurse's office.**

_____ _____
Signature of Parent/Guardian Date

OVER-THE-COUNTER MEDICATIONS WILL BE KEPT IN THE NURSE'S OFFICE UNTIL THE END OF THE SCHOOL YEAR.
ABSOLUTELY NO MEDICATIONS WILL BE GIVEN WITHOUT WRITTEN PERMISSION.

RETURN TO NURSE'S OFFICE

LOWER CAPE MAY REGIONAL SCHOOL DISTRICT

Request for Prescribed medication to be given at school

I request the nurse to see that _____ Grade _____ ID#_____
(Name of Student)

receives the following medication _____

prescribed by _____ for _____
(Name of doctor) (Reason/Illness)

The medication is to be given on _____

_____ _____
Signature of Parent/Guardian Date

***** Medication <u>MUST</u> be in the prescription bottle and will stay in the nurse's office.**

- **<u>ABSOLUTELY NO MEDICATIONS WILL BE GIVEN WITHOUT WRITTEN PERMISSION.</u>**

LOWER CAPE MAY REGIONAL SCHOOL DISTRICT

ID # _____

Last Name _____ First _____ Initial _____ Date of Birth (MM/DD/YYYY) _____

Address _____ School _____

City _____ Zip _____ Grade _____

Home Phone (_____) _____ Teacher/H.R. _____

To Parent/Guardian: To serve your child in case of accident or sudden illness, it is necessary that you give the following information for EMERGENCY CALLS.

Parent/Guardian 1 Name _____ Relationship _____

Phone Numbers: Home (____)_____ Cell (____)_____ Work (____)_____ Email _____

Parent/Guardian 2 Name _____ Relationship _____

Phone Numbers: Home (____)_____ Cell (____)_____ Work (____)_____ Email _____

List two neighbors or nearby relatives who will assume temporary care of your child(ren) if you cannot be reached:

Neighbor/Relative 1 Name _____ Address _____

Phone Numbers: Home (____)_____ Cell (____)_____ Work (____)_____ Email _____

Neighbor/Relative 2 Name _____ Address _____

Phone Numbers: Home (____)_____ Cell (____)_____ Work (____)_____ Email _____

Please list other children attending New Jersey Public Schools (Name, Grade, School)

_____ _____

_____ _____

_____ _____

☐ **Please check this box if there has been a name change of parent/guardian, address or telephone number.**

Does this child have any health insurance including NJ FamilyCare/Medicaid, Medicare, private or other?

☐ **NO** My child **does not** have health insurance. You may release my name and address to the NJ FamilyCare Program to contact me about health insurance.

Signature: _____ **Printed Name:** _____ **Date:** _____

Written consent required pursuant to 20 U.S.C. § 1232g(b)(1) and 34 C.F.R. 99.30(b).

NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information visit www.njfamilycare.org to apply online or call 1-800-701-0710.

☐ **YES** My child has health insurance.

List any medical/surgical care your child has received during the past year:

_____

Dental Exam _____ Date _____ Braces

Eye Exam _____ Date _____ Glasses /Contacts

Allergy _____ Kind _____ Medications

Allergic Reaction _____ Date _____ Medications

Immunizations/Tetanus _____ Date _____ Type

Restrictions _____ Type

Doctor _____ Phone _____

Dentist _____ Phone _____

Hospital _____ Hospital Name/Address Phone _____

I, the undersigned, do hereby authorize officials of New Jersey Public Schools to contact directly the person(s) named on this card and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of said child. In the event that physicians, other persons named on this card, or parents/guardians cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child. I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

_____ _____

Signature of Parent(s) / Guardian(s) **Date**

PLEASE RETURN TO NURSES OFFICE

Lower Cape May Regional School District
687 Route 9 Cape May, NJ 08204
609-884-3475

High School
Lawrence Ziemba, Principal
School Nurse Ext. 238

Teitelman School
Gregory Lasher, Principal
Morgan Dougherty, School Nurse Ext. 275

Parent Notification of Scoliosis Screening

Dear Parent/ Guardian:

There will be a screening program for scoliosis for students in **Grades 8th, 10th and 12th**, as required by state law, which will be carried out over the current school year.

Scoliosis is defined as a condition of the spine in which the spine may curve to the left or right. It is most commonly found during the time of rapid growth and may progress if left untreated. The purpose of this screening program is to recognize scoliosis at its earliest stages.

Students will be screened during a gym or health class depending on their schedule. A student may be exempted from this examination if requested by the parent/guardian in writing.

You are also invited to be present if you desire. However, females will be screened by the nurse or a female PE teacher. You will need to complete the form below so you can be advised of the time to be present. Whether you are present or not, you will be informed of any abnormal screen.

Thank You for your cooperation.

LCMR School Nurse

Morgan Dougherty
Teitelman School Nurse

Name of Student: _____ Grade_____

_____ Please EXAMINE my child.
_____ Please Exempt my child.
_____ I would like to be present during my child's screen. Please contact me at _____ to schedule a time.

Signature of Parent/ Guardian: _____ Date: _____