FUTURE FOUNDATIONS ACADEMY **www.escnj.k12.nj.us**

EDUCATIONAL SERVICES COMMISSION OF NEW JERSEY

1690 Stelton Road, Piscataway, New Jersey 08854 (732) 339-9331 Fax (732) 339-9441

Sandy Giardino
Principal

Katie Feiles
Vice Principal

Kate Johnson
Supervisor

School Year
2018-2019

Dear Parent/Guardian:

The Future Foundations Academy Health Packet is enclosed for your completion.

School laws require that your child be given a physical examination for the protection of health. The examination should be scheduled for new entrants into the school system, as well as subsequent examinations of students at least one time during each developmental stage, that is; early childhood (preschool through grade three), preadolescence (grades four through six) and adolescence (grade seven through twelve).

The primary responsibility for the total health needs for the student rests with the family and the child's own physician. A physical examination by a private physician allows a more thorough examination and a more individual approach to each pupil and his/her needs. It will also provide an opportunity to receive additional immunizations as needed.

Please have the enclosed examination form completed by your physician if your child hasn't had a physical within the past year. <u>Also, please fill out the additional forms enclosed and return to the school.</u>

If you need any additional information, please do not hesitate to contact me at:
(732) 777-9860 extension 6170 / wstawick@escnj.us.

Please know that this information is essential, and must be kept on file at Future Foundations Academy.

Your cooperation in this matter is greatly appreciated.
Sincerely,

Mrs. Wendy Stawick, R.N.
Future Foundations Academy Nurse

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HEALTH SCREENING PERMISSION FORM 2018-19

STUDENT'S NAME: ____

Dear Parent/Guardian:

In accordance with New Jersey Law, N.J.A.C.6A:16-2.2, each district Board of Education will ensure health screenings for students. Health screenings may include height, weight, hearing, blood pressure, vision and scoliosis. Screenings may be conducted by a school physician, school nurse, or other school personnel properly trained.

Please complete the health screening permission form below and return to the Future Foundations Academy Health Office.

_____ I give permission for my child to participate in health screenings at school.

_____ I do not give permission for my child to participate for health screenings at school.

Signature of Parent /Guardian______________________________ **Date:**_______________

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AUTHORIZATION FOR NON-PRESCRIPTION MEDICATION 2018-19

Child's name____

Dear Parent/Guardian:

Sometimes children develop fever, headaches, or pain to illness or a simply injury while they are at school. The school nurse would like your permission to administer over-the-counter medication to your child when it happens. We will usually use acetaminophen (sold as Tylenol). The dose will be according to the child's weight and will be set by our school physician. You may prefer another medication such as ibuprofen, (sold as Advil and Motrin). Ibuprofen is also preferred for menstrual cramps. The school will supply Tylenol and Motrin. If you wish to give the nurse permission to use one of these medications for fever, pain or menstrual cramps, please sign the appropriate line or lines below.

I give permission for the school nurse,

_______ **To administer acetaminophen (ex. Tylenol)**

_______ **To administer ibuprofen (ex. Advil/Motrin)**

Also, sometimes children develop allergic reaction (itching, swelling, or rash) while they are in school. The school nurse would like your permission to administer over-the-counter medication. We will usually use diphenhydramine (sold as Benadryl). If you wish to give the nurse permission to use one of these medications for allergic reaction, please select and sign the line below.

_______ **To administer diphenhydramine (Benadryl)**

Signature of Parent / Guardian____

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Our school's health office recommends an annual dental examination by your family dentist for your child.

Please return this form to the school nurse as soon as possible following your child's dental examination.

If there is any reason why you cannot have a dental examination done, please call 732-339-9331 ext. 3470/3480.

School Nurse

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DENTAL EXAMINATION REPORT

I have examined _____________________________________on __________________________
(Name of student) (Date)

1. There is no need for corrective work at this time.
2. Treatment has been completed.
3. There is need for dental care at this time.
An appointment has been scheduled: YES _______________________ NO__________
(Date of next Appointment)

Medical Provider Signature: ____

Medical Provider Print Name:____

Please Stamp Here