Lacordaire Academy
Health Services

2020-2021
HEALTH PACKET

LACORDAIRE ACADEMY

Health Office

Student Forms Checklist

Form	Return	Due By
Physical Exam must be within 365 days - **FOR NEW STUDENTS AND STUDENT ATHLETES ONLY**	***Return Required***	Due before 1st day of school for new students Due 2 weeks before 1st athletic practice for athletes
Immunization Record - Current & Up to Date	***Return Required***	Due before 1st day of school
Annual Student Health History Update	***Return Required***	Due before 1st day of school
Over the Counter Medication Authorization Form	Return Optional but highly recommended	Nurse **can not** administer any over the counter medications in school without this form completed by physician and signed by physician and parent
Medication Consent Form	Return Optional	For any medications to be given not included on the OTC Medication Form EXCEPT Bendadryl, EpiPen, Asthma, Seizure or Diabetes Medications (see below for applicable forms)
Forms Required if applicable to student		
Food Allergy Action Plan	***Return Required if applicable***	**Must have forms completed and on file in the Health Office with the prescribed medication before the 1st day of school**
Asthma Action Plan		
Diabetes Action Plan		
Seizure Action Plan		

Revised 07/2020

LACORDAIRE ACADEMY

HEALTH OFFICE

Dear Parents/Guardians:

I hope you and your families are all safe and well. I would like to offer some tips on completing the required paperwork for the upcoming school year. I know that it can be overwhelming and tedious, but please understand that these requirements (mostly state laws) are here to protect your children and set them up for a healthy and productive school environment.

1. **ALL NEW STUDENTS and student athletes** are required to have a current physical exam on file. That means the physical exam must be less than 365 days old. For student athletes, if that physical exam will expire during the school year, you will be required to provide a new one in order to continue to participate in sports. Nonetheless, we do recommend having your child see a pediatrician on a yearly basis as it is important to monitor their growth and health.
2. The Annual Student Health History Update form is **required for all students**. This is particularly important since not all students will be submitting an annual physical exam. Please do not omit this form.
3. The school nurse is **NOT** able to administer over-the-counter medications such as acetaminophen (Tylenol) and ibuprofen (Advil) unless the student's physician and parent/guardian has signed for these medications on the enclosed Authorization for Over the Counter Medications form. ** Please have this form completed so I can help your child when they come to the health office and avoid a day missed at school. If you do not agree to have your child medicated at school, please attach the form stating: I do not give permission to have my child medicated at school.
4. Immunization records must be current and submitted for all **NEW students and students entering Pre-K, Kindergarten, 6th and 9th grades.** The State of New Jersey requires certain vaccine boosters for those students and therefore we need to have documentation of the student being up to date. Students will not be permitted to enter school without the required vaccines.
5. All student-athletes must turn in the state required Pre-Participation Physical Evaluation Form prior to the first practice of that sport or they will not be allowed to participate in any practices or games until all of their paperwork is completed, turned in and they have been cleared.
6. If your child has any food allergies or insect bites (bee stings) or has Asthma and requires emergency or maintenance medication, a Life-Threatening Allergy Action Plan or an Asthma Action Plan MUST be filled out with the medication name(s) and dosages and signed by both the physician and parent/guardian. In addition, the medication (Epi-pens, Benadryl, Asthma Inhalers) must be brought in and given to the school nurse. The medications must not be expired and the student's name must be on the medication and in the original labeled container.
7. All medical forms are also available at http://lacordaireacademy.com/student-life/student-health/medical-forms/
8. Please upload all forms to www.studentehr.com, if you have any difficulties doing so please contact the health office by email.
9. Please make a copy for your own records of all forms submitted to Lacordaire. You can do it the old fashioned way or with your smart phone.

Thank you for your cooperation. Let's have a happy and healthy fall semester.

Sincerely,
Tammy Zolnowsky, RN
Lacordaire Academy School Nurse
nurse@lacordaire.net
973-744-1156 x18

Rev
07/2020

LACORDAIRE ACADEMY

ANNUAL STUDENT HEALTH HISTORY UPDATE

Name:	DOB: Age: Grade:	Gender: ☐ M ☐ F
Parent/Guardian: (person completing this form)	Home Phone: Cell Phone:	Date:

In the past 12 months, has your child:	YES	NO	If Yes, please explain and include date:
Had an ongoing medical condition	☐	☐	
Seen a medical specialist	☐	☐	
Had allergies: ☐food ☐environmental ☐insect ☐medication ☐other	☐	☐	
Been hospitalized	☐	☐	
Had an operation	☐	☐	
Had an injury requiring an Emergency Room visit	☐	☐	
Missed 5 days of school in a row due to illness/injury	☐	☐	
Had a bone/muscle injury	☐	☐	
Passed out, had a concussion or serious head injury	☐	☐	
Had a convulsion/seizure	☐	☐	
Had a vision problem or condition	☐	☐	☐ glasses ☐ contacts
Had a hearing problem or condition	☐	☐	☐ hearing aid ☐ cochlear implant
Worn dental bridge, braces or mouthpiece	☐	☐	
Have any family members under the age of 50 ever:	**YES**	**NO**	**If Yes, please specify:**
Had a heart attack	☐	☐	
Had other serious health problems	☐	☐	

CHECK ALL THAT APPLY TO YOUR CHILD:

- ☐ ADHD/ADD
- ☐ Asthma/trouble breathing
- ☐ Autism/Asperger
- ☐ Cancer
- ☐ Dental Injuries
- ☐ Diabetes
- ☐ Ear Infections
- ☐ GI Conditions (ulcer, reflux, IBS)
- ☐ Headaches/migraines
- ☐ Heart Conditions
- ☐ High Blood Pressure
- ☐ Mental Health Condition: (Depression, eating disorder, anxiety, OCD, ODD, etc.)
- ☐ Scoliosis
- ☐ Single Organ (☐kidney, ☐testicle)
- ❑ Coronavirus (COVID-19) Diagnosis
  - ☐ If yes, symptomatic or hospitalized?
  - ☐ Any household member diagnosed with Coronavirus (COVID-19)?
- ❑ Single Organ (☐kidney, ☐testicle)
- ❑ Skin Condition
- ❑ Speech Condition
- ❑ Urinary Condition

CURRENT MEDICATIONS	YES	NO	Please list name, dose, time(s)
Given at school	☐	☐	
Taken at home	☐	☐	
TREATMENTS	**YES**	**NO**	
During or outside of school	☐	☐	☐insulin/blood glucose monitoring ☐inhaler/nebulizer/peak flow monitoring ☐special diet

Is there any condition that would prevent your child from participating in physical education or sports?

☐No ☐Yes: _____

Please list any additional concerns: (use back of sheet if necessary) _____

To ensure the care of my child, I agree that pertinent health information may be shared with appropriate school staff, and may be forwarded to emergency medical personnel in emergency situations. I agree to notify the school nurse of any changes in medication, dosage, or change in any health status of my child. I agree if any of the above information changes, I will notify the school immediately. I understand that in case of an emergency the school will first attempt to contact me. If I cannot be reached, I authorize the transport of my child to a hospital and authorize any physician or medical personnel to carry out any diagnostic procedures or emergency care deemed necessary. I will accept full financial responsibility for charges connected with the use of an ambulance and charges connected with any medical care necessary. I acknowledge that all foregoing above information is true and correct.

Parent/Guardian Signature: _____ Date: _____

Updated 7/2020

ATTENTION PARENT/GUARDIAN: The preparticipation physical examination (page 3) must be completed by a health care provider who has completed the Student-Athlete Cardiac Assessment Professional Development Module.

PREPARTICIPATION PHYSICAL EVALUATION
HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep a copy of this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

_____

_____

_____

_____

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

HE0503 9-2681/0410

New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

PREPARTICIPATION PHYSICAL EVALUATION

THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

1. Type of disability		
2. Date of disability		
3. Classification (if available)		
4. Cause of disability (birth, disease, accident/trauma, other)		
5. List the sports you are interested in playing		
	Yes	**No**
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

_____

_____

_____

_____

_____

Please indicate if you have ever had any of the following.

	Yes	**No**
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers here

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

NOTE: The preparticiaption physical examination must be conducted by a health care provider who 1) is a licensed physician, advanced practice nurse, or physician assistant; and 2) completed the Student-Athlete Cardiac Assessment Professional Development Module.

PREPARTICIPATION PHYSICAL EVALUATION
PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

1. **Consider additional questions on more sensitive issues**
   - **Do you feel stressed out or under a lot of pressure?**
   - **Do you ever feel sad, hopeless, depressed, or anxious?**
   - **Do you feel safe at your home or residence?**
   - **Have you ever tried cigarettes, chewing tobacco, snuff, or dip?**
   - **During the past 30 days, did you use chewing tobacco, snuff, or dip?**
   - **Do you drink alcohol or use any other drugs?**
   - **Have you ever taken anabolic steroids or used any other performance supplement?**
   - **Have you ever taken any supplements to help you gain or lose weight or improve your performance?**
   - **Do you wear a seat belt, use a helmet, and use condoms?**
2. **Consider reviewing questions on cardiovascular symptoms (questions 5–14).**

EXAMINATION		
Height Weight	☐ Male ☐ Female	
BP / (/) Pulse	Vision R 20/ L 20/	Corrected ☐ Y ☐ N
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychialric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason _____

Recommendations _____

_____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) (print/type) _____ Date of exam _____

Address _____ Phone _____

Signature of physician, APN, PA _____

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New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

PREPARTICIPATION PHYSICAL EVALUATION
CLEARANCE FORM

Name _____ Sex ☐ M ☐ F Age _____ Date of birth _____

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____
  Reason _____

Recommendations _____

_____

_____

_____

_____

_____

EMERGENCY INFORMATION

Allergies _____

_____

_____

_____

_____

_____

Other information _____

_____

_____

_____

_____

HCP OFFICE STAMP

SCHOOL PHYSICIAN:

Reviewed on _____
(Date)

Approved _____ Not Approved _____

Signature: _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) _____ Date _____

Address _____ Phone _____

Signature of physician, APN, PA _____

Completed Cardiac Assessment Professional Development Module

Date _____ Signature _____

New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

LACORDAIRE ACADEMY

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973.744.1156 • Fax 973.783.9521

LACORDAIRE ACADEMY

IMMUNIZATION REGISTRY NUMBER

Name of Child (Last, First, M.I.)	Date of Birth (Mo/Day/Yr)	Sex ☐ Male ☐ Female
PARENT OR GUARDIAN — NAME	TELEPHONE NO.	
ADDRESS		

VACCINE TYPE	1st Dose Mo/Day/Yr	2nd Dose Mo/Day/Yr	3rd Dose Mo/Day/Yr	4th Dose Mo/Day/Yr	5th Dose Mo/Day/Yr	LEAD SCREENING Test Date	Result
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination (If Td or DT, indicate)							
Tdap							
POLIO – INACTIVATED POLIO VACCINE (IPV) If oral vaccine, indicate (OPV)							
MEASLES, MUMPS, RUBELLA (MMR)					Document below single antigen vaccine receipt, Serology titers, or varicella disease history		
HAEMOPHILUS B (HIB)					Hepatitis B	Date:	Titer:
HEPATITIS B					Varicella	Date:	Titer:
VARICELLA					Measles	Date:	Titer:
PNEUMOCOCCAL CONJUGATE**					Mumps	Date:	Titer:
MENINGOCOCCAL					Rubella	Date:	Titer:
HEPATITIS A***							
HPV (HUMAN PAPILLOMAVIRUS)***							
OTHER, SPECIFY:							

☐ Provisional admission attached – Date Granted: _____ ☐ Medical exemption attached ☐ Religious exemption attached

** REQUIRED FOR DAY/CHOLD CARE ENROLLEES (2 Months-5th Birthday Only) *** Not Required

_____ M.D.

Address: _____

_____

Phone: _____

MD OFFICE STAMP

LACORDAIRE ACADEMY

HEALTH OFFICE

Authorization Form for Over the Counter Medications

Student's Name _____ **Grade**_____

By law the school nurse needs an approved form from the student's physician and parent/guardian permission before she can administer any form of medication.

IMPORTANT:
Physician, please initial all medications/orders you would like the above student receive at school.

1. _____Ibuprofen (Advil, Motrin) **Child 12 and older:** 200-400mg every 6 hours prn headache, menstrual cramps or fever; **Child 4-11:** 5-10mg/kg every 6 hours prn fever or pain
2. _____Acetaminophen (Tylenol) **Child 12 and older:** 325-650mg every 4 hours prn headache, pain or fever; **Child under 12:** 10-15mg/kg every 4 hours prn headache, pain or fever
3. _____Benadryl Liquid (**Child 2-5yrs:** 6.5mg every 4 hours prn; **Child 6-11yrs**: 12.5-25mg every 4 hours prn; **Child 12 and over:** 25-50mg every 4 hours prn) allergies or allergic reaction.
4. _____Tums 2-4 tablets prn upset stomach
5. _____Cough Drops, 1 every 2 hours prn cough
6. _____Calamine Lotion prn for itching or rash
7. _____Sterile Eye Wash prn for foreign body removal

Physician's Signature _____ **Date**_____

Physician's Office Stamp

Parent/Guardian Signature _____ **Date**_____

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