

AUDUBON PUBLIC SCHOOLS

**Haviland Avenue Elementary School**

240 S. Haviland Avenue  
Audubon, New Jersey 08106  
(856) 546-4922  
**Ann Alston, R.N., B.S.N**

**Mansion Avenue Elementary School**

300 Mansion Avenue  
Audubon, New Jersey 08106  
(856) 546-4926  
**Pat Snyder, R.N., B.S.N.**

Dear Parents/Guardians,

Welcome to the Audubon Public Schools. School Health Policies in our school are based on laws and regulations mandated by the State of New Jersey. **One such law requires parents or guardians to provide documentation of their child's physical exam within 30 days of enrollment.** The examination report must state what, if any, modifications are required for full participation in the school program.

If a physical exam is scheduled or was performed within the last 365 days, please have that exam recorded by the examining physician on the school form and return it to the nurse's office.

If you need information about local physicians or NJ Family Care, which offers affordable health insurance for uninsured children in New Jersey, please contact the nurse at the school your child will be attending.

Thank you for your cooperation.

Sincerely,

Elementary School Nurses

**Audubon Public Schools**  
 350 Edgewood Avenue, Audubon, New Jersey 08106-1545  
 Phone (856) 547-7695 • Fax (856) 546-8550  
[www.audubonschools.org](http://www.audubonschools.org)

**HEALTH HISTORY**

**Student Name** \_\_\_\_\_ **Grade** \_\_\_\_\_

**Date of Birth** \_\_\_\_\_ **Age** \_\_\_\_\_ **Sex:** **Male** **Female**

**Does your child have any of the following:**

	No	Yes	
Allergy: <ul style="list-style-type: none"> <li>• Bee Sting</li> <li>• Food</li> <li>• Medication</li> </ul> <b>Epinephrine Ordered by Doctor</b>			bee sting reaction: _____ food & reaction: _____ medication & reaction: _____ <a href="#">Click here for HEALTHCARE PROVIDER'S ORDERS FOR ALLERGY EMERGENCY TREATMENT PACKET</a>
Allergies: Hayfever/Seasonal			season & symptoms:
ADD/ADHD			
Anemia			
Asthma			mild____ severe____ <a href="#">Click here for the ASTHMA TREATMENT PLAN</a> – required by N.J. Law
Behavioral Issues			
Broken Bone History			
Chronic Constipation			
Developmental Delay			
Dental Problems			
Diabetes			
Eczema			
Fainting Spells			
Frequent Ear Infections <ul style="list-style-type: none"> <li>• Earaches</li> <li>• Hearing Loss</li> <li>• Tubes in Ears</li> </ul>			
Headaches			
Muscle Problems			
Nosebleeds			
Physical Handicap			
Premature or Low Birth Weight			
Seizures/Epilepsy/Tics			
Speech Difficulty or Delay			
Stomachaches			
Vision problem <ul style="list-style-type: none"> <li>• Color Deficiency</li> <li>• Corrective Lenses</li> <li>• Patch</li> </ul>			type of corrective lens? _____ right____ left____

**Has your child had any of the following:**

Illness	No	Yes	Date(s) of Illness
Chickenpox			
Measles			
Mumps			
German Measles			
Lyme Disease			
Strep. Infection			
Scarlet Fever			
Rheumatic Fever			
Pneumonia			
Hepatitis (type)			
Mononucleosis			

Student Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Is your child currently receiving daily medication?**

NO \_\_\_ YES \_\_\_

- If YES, please give name of medication, amount and reason: \_\_\_\_\_
- Will your child require the medication during school hours? NO \_\_\_ YES \_\_\_

[Click here for the MEDICATION CONSENT FORM](#), which must be completed by parent and doctor for any medication, including over the counter medication, which needs to be given during school hours.

**Was a health problem and/or handicap present at birth?**

NO \_\_\_ YES \_\_\_

- At what age was diagnosis made? \_\_\_\_\_  
Diagnosis: \_\_\_\_\_

**List any operations, injuries or hospitalizations and dates:**

*Operations/Injuries/Hospitalizations*

*Date*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- Do any of the conditions still affect your child? NO \_\_\_ YES \_\_\_
- If YES, please list \_\_\_\_\_
- Physical Ed Activity: Does condition restrict his/her activities? NO \_\_\_ YES \_\_\_

**Do you have any concerns about your child's health? If so, please**

**describe** \_\_\_\_\_

**I give permission for health concerns to be shared with appropriate staff having contact with my child.**

YES \_\_\_ NO \_\_\_

Routine screenings are performed, in the Audubon Public schools, by certified school nurses as part of a comprehensive health program required by New Jersey law. Pupils can be exempted from screenings with a written request from the parent/guardian.

**Authorization for Medical Treatment**

*I/We, the undersigned, do hereby authorize officials of the Audubon School District to contact directly the persons named on the "EMERGENCY CONTACT INFORMATION" and do authorize the appropriate school personnel to render first aid as may be deemed necessary in an emergency, for the health of the said child. Pertinent medical information may be shared with school personnel as needed.*

*In the event that parents or other persons named on the "EMERGENCY CONTACT INFORMATION" cannot be contacted, the school officials are hereby authorized to take whatever action necessary in their judgment, for the health of aforesaid child, including transportation to the nearest medical emergency facility.*

*I will not hold the Audubon School District financially responsible for the emergency care and/or transportation for said child.*

**Name of Child's Doctor:** \_\_\_\_\_ **Telephone #** \_\_\_\_\_

**Date of Last Medical Exam:** \_\_\_\_\_

**Name of Child's Dentist:** \_\_\_\_\_ **Telephone #** \_\_\_\_\_

**Date of Last Dental Exam:** \_\_\_\_\_

**Health Insurance Information:** Does child have health insurance?

YES \_\_\_ Name of Insurance: \_\_\_\_\_  
Name of Subscriber: \_\_\_\_\_  
I.D. Number: \_\_\_\_\_  
Group Number: \_\_\_\_\_

NO \_\_\_ Do you want Medicaid/NJ Family Care to contact you about free or low-cost health insurance? No \_\_\_ Yes \_\_\_

Parent/Guardian Printed Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Printed Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Name \_\_\_\_\_ Grade \_\_\_\_\_ Birthdate \_\_\_\_\_

**Physical Exam**

**Immunizations**

complete **or** attach immunization record

Ears \_\_\_\_\_ Hearing \_\_\_\_\_  
Eyes \_\_\_\_\_ Vision \_\_\_\_\_  
Lymph Glands \_\_\_\_\_  
Thyroid \_\_\_\_\_  
Nose \_\_\_\_\_  
Throat \_\_\_\_\_  
Teeth-Mouth \_\_\_\_\_  
Heart \_\_\_\_\_  
Lungs \_\_\_\_\_  
Abdomen \_\_\_\_\_  
Hernia \_\_\_\_\_  
Genito-urinary \_\_\_\_\_  
  
Orthopedic      Structural \_\_\_\_\_  
                         Posture \_\_\_\_\_  
                         Feet \_\_\_\_\_  
  
Skin \_\_\_\_\_  
Nutrition \_\_\_\_\_  
Nervous System \_\_\_\_\_  
Speech \_\_\_\_\_  
Other \_\_\_\_\_  
General Appearance \_\_\_\_\_

DTP \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Tdap \_\_\_\_\_ (grade 6)  
Polio \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
MMR \_\_\_\_\_  
MMR Booster \_\_\_\_\_  
  
Hib \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Hepatitis B \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medical Illnesses \_\_\_\_\_

Medications \_\_\_\_\_

Allergies \_\_\_\_\_

Reaction \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

Blood Pressure \_\_\_\_\_

Recommendations \_\_\_\_\_

State what, if any, modifications are required for student's full participation in school program \_\_\_\_\_  
\_\_\_\_\_

**Date of physical exam:** \_\_\_\_\_

**Dr.'s Name (printed or stamped)**

Varicella Vaccine \_\_\_\_\_

History or Lab Evidence of Varicella \_\_\_\_\_

Hepatitis A Vaccine \_\_\_\_\_

Pneumococcal conjugate series

#1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_ #4 \_\_\_\_\_ (13) \_\_\_\_\_

Meningococcal vaccine \_\_\_\_\_ (grade 6)

Menactra \_\_\_\_\_ or Metamune \_\_\_\_\_

Hepatitis A \_\_\_\_\_

Influenza Vaccine \_\_\_\_\_

(required annually until age 5)

TB Screening Tested \_\_\_\_\_

Read \_\_\_\_\_

Result \_\_\_\_\_

**Dr.'s Signature:** \_\_\_\_\_

# Audubon Public Schools

350 Edgewood Avenue, Audubon, New Jersey 08106-1545

Phone (856) 547-7695 • Fax (856) 546-8550

[www.audubonschools.org](http://www.audubonschools.org)

## RELEASE FOR STUDENT RECORDS/VERBAL INFORMATION

_____	_____	_____	_____
<b>Student's Last Name</b>	<b>First Name</b>	<b>Middle Name</b>	<b>Suffix</b>

D.O.B.: \_\_\_\_\_

School Last Attended: \_\_\_\_\_ Grade Last Attended \_\_\_\_\_

Address \_\_\_\_\_

<i>Bldg.#</i>	<i>Street</i>	<i>City</i>	<i>State</i>	<i>Zip Code</i>
---------------	---------------	-------------	--------------	-----------------

Tel. No. (      ) \_\_\_\_\_ Fax No. (      ) \_\_\_\_\_

***This child has registered in our school for the current year. Please forward the following information:***

- |                                 |   |
|---------------------------------|---|
| _____ Official Transcript       | _____ State Issued ID (SID #)                                 |
| _____ Standardized Test Records | _____ Disciplinary Records                                    |
| _____ Health Records            | _____ <b>Special Education &amp; Related Services Records</b> |
| _____ Others _____              |   |

***To the school / office checked below:***

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> <b>HAVILAND AVENUE ELEM. SCHOOL</b><br>240 South Haviland Avenue<br>Audubon, NJ 08106<br>Phone: 856-546-4922<br>Fax: 856-547-1248 | <input type="checkbox"/> <b>MANSION AVENUE ELEM. SCHOOL</b><br>300 Mansion Avenue<br>Audubon, NJ 08106<br>Phone: 856-546-4926<br>Fax: 856-547-1483 | <input type="checkbox"/> <b>JR/SR HIGH SCHOOL</b><br>350 Edgewood Ave.<br>Audubon, NJ 08106<br>Phone: 856-547-7695<br>Fax: 856-547-1901 |
|--|--|---|

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**To Whom It May Concern:**

***This will serve as authorization to send the records requested above to the Audubon Public Schools.***

\_\_\_\_\_  
**Parent / Guardian Printed Name**

\_\_\_\_\_  
**Parent / Guardian Printed Name**

\_\_\_\_\_  
**Parent / Guardian Signature**

\_\_\_\_\_  
**Parent / Guardian Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Date**

# Information Regarding SEMI Parental Consent

**Background:** The State of New Jersey has participated in a Federal program, Special Education Medicaid Initiative (SEMI), since 1994. The program assists school districts by providing partial reimbursement for medically-related services listed on a student's Individualized Educational Program (IEP).

The SEMI program is under the auspices of the New Jersey Department of the Treasury through its collaboration with the New Jersey Department of Education and New Jersey Division of Medicaid Assistance and Health Services.

In 2013, the regulations regarding Medicaid parental consent for school-based services changed. Now the regulations require that, prior to accessing a child's public benefits or insurance for the first time, and annually thereafter, school districts must provide parents/guardians written notification and obtain a one-time parental consent.

## **Is there a cost to you?**

No. IEP services are provided to students while at school at **no** cost to the parent/guardian.

## **Will SEMI claiming impact your family's Medicaid benefits?**

The SEMI program **does not** impact a family's Medicaid services, funds, or coverage limits. New Jersey operates the school-based services program differently than the family's Medicaid program. The SEMI program **does not** affect your family's Medicaid benefits in any way.

## **What type of services does the School-Based Services program cover?**

- Evaluations
- Psychological Counseling
- Speech Therapy
- Audiology
- Occupational Therapy
- Nursing
- Physical Therapy
- Specialized Transportation

## **What type of information about your child will be shared?**

In order to submit claims for SEMI reimbursement, the following types of records may be required: first name, last name, middle name, address, date of birth, student ID, Medicaid ID, disability, service dates and the type of services delivered.

## **Who will see this information?**

Information about your child's special education program may be shared with the New Jersey Division of Medicaid Assistance and Health Services and its affiliates, including the Department of the Treasury and the Department of Education for the purpose of verifying Medicaid eligibility and submitting claims.

## **What if you change your mind?**

You have the right to withdraw consent to allow for Medicaid billing at any time. If you would like to revoke consent, please contact the school in which your child is enrolled in writing.

## **Will your consent or refusal to consent affect your child's services?**

No. Your school district is still required to provide services to your child pursuant to his or her IEP, regardless of your Medicaid eligibility status or your willingness to consent for SEMI billing.

## **What if you have questions?**

Please call your school district's Special Education department with questions or concerns, or to obtain a copy of the parental consent form.

**AUDUBON PUBLIC SCHOOLS**  
**CHILD STUDY TEAM**

**350 Edgewood Avenue, Audubon, New Jersey 08106**  
**Phone: (856) 547-7695, ext. 4152 Fax: (856) 547-2303**

Special Education Medicaid Initiative (SEMI) Parental Consent Form

Audubon School District

Our school district is participating in the Special Education Medicaid Initiative (SEMI) program that allows school districts to bill Medicaid for services that are provided to students.

In accordance with the Family Educational Rights and Privacy Act, 34 CFR §99.30 and Section 617 of the IDEA Part B, consent requirements in 34 CFR §300.622 require a one-time consent before accessing public benefits.

This consent establishes that your child's personally identifiable information, such as student records or information about services provided to your child including evaluations, and services as specified in your child's Individualized Education Program (IEP) (occupational therapy, physical therapy, speech/language therapy, psychological counseling, audiology, nursing and specialized transportation) may be disclosed to Medicaid and the Department of the Treasury for the purpose of receiving Medicaid reimbursement at the school district.

**Please complete the information on the form, sign and return it at your earliest convenience to the address above. Elementary students may return the form in a sealed envelope labeled CST to their teacher who will forward it to the Child Study Team office. High school students may return the form in a sealed envelope to the Child Study Team office. Thank you.**

As parent/guardian of the child named below, I give permission to disclose information as described above and I understand and agree that Medicaid may access my child's or my public benefits or insurance to pay for special education or related services under Part 300 (services under the IDEA). I understand that the school district is still required to provide services to my child pursuant to his or her IEP, regardless of my Medicaid eligibility status or willingness to consent for SEMI billing.

I understand that billing for these services by the district *does not* impact my ability to access these services for my child outside of the school setting, nor will any cost be incurred by my family including co-pays, deductibles, loss of eligibility or impact on lifetime benefits.

Child's Name: \_\_\_\_\_

Child's Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

I give consent to bill for SEMI: Yes  No

This consent can be revoked at any time by contacting the administrator at your child's school, in writing.

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## STUDENT RESIDENCY VERIFICATION

STUDENT NAME \_\_\_\_\_

GRADE \_\_\_\_\_

**School:**

Haviland Avenue Elementary School

Mansion Avenue Elementary School

Jr/Sr High School

**In accordance with New Jersey state law (NJSA 18A:38-1 and 18A-7B-12), it is necessary to determine the residency of students entering the school district.**

Please indicate the applicable student resident facility:

1.  Own my own residence within Audubon Borough
2.  Rent my residence within Audubon Borough
3.  Share housing and expenses in Audubon Borough with family member / friend by choice
4.  Reside with family member / friend in Audubon Borough due to economic hardship
5.  Reside in domestic violence shelter / runaway youth shelter / other shelter, or any other transitional living program
6.  Reside in motel, hotel, park, or campground due to lack of adequate housing
7.  Reside in car or RV or in a public place (such as a bus station)
8.  Reside in sub-standard housing, such as an abandoned building
9.  Student(s) awaiting foster care placement
10.  Parents are migrant workers
11.  Reside in home for adolescent school-age mothers
12.  Other: Please explain - \_\_\_\_\_

**NONE OF THE ABOVE SITUATIONS APPLY**

\_\_\_\_\_  
Parent / Guardian Printed Name

\_\_\_\_\_  
Parent / Guardian Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent / Guardian Signature

\_\_\_\_\_  
Parent / Guardian Signature

\_\_\_\_\_  
Date

-OR-

\_\_\_\_\_  
Unaccompanied Youth – Print Name

\_\_\_\_\_  
Unaccompanied Youth-Signature

\_\_\_\_\_  
Date