Audubon Public Schools
350 Edgewood Avenue, Audubon, New Jersey 08106-1545
Phone (856) 547-7695 • Fax (856) 546-8550
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: • Bee Sting • Food • Medication **Epinephrine Ordered by Doctor**	☐	☐	bee sting reaction: _____ food & reaction: _____ medication & reaction:_____ Click here for HEALTHCARE PROVIDER'S ORDERS FOR ALLERGY EMERGENCY TREATMENT PACKET
Allergies: Hayfever/Seasonal	☐	☐	season & symptoms:
ADD/ADHD	☐	☐	
Anemia	☐	☐	
Asthma	☐	☐	mild☐ severe☐ Click here for the ASTHMA TREATMENT PLAN – required by N.J. Law
Behavioral Issues	☐	☐	
Broken Bone History	☐	☐	
Chronic Constipation	☐	☐	
Developmental Delay	☐	☐	
Dental Problems	☐	☐	
Diabetes	☐	☐	
Eczema	☐	☐	
Fainting Spells	☐	☐	
Frequent Ear Infections • Earaches • Hearing Loss • Tubes in Ears	☐	☐	
Headaches	☐	☐	
Muscle Problems	☐	☐	
Nosebleeds	☐	☐	
Physical Handicap	☐	☐	
Premature or Low Birth Weight	☐	☐	
Seizures/Epilepsy/Tics	☐	☐	
Speech Difficulty or Delay	☐	☐	
Stomachaches	☐	☐	
Vision problem • Color Deficiency • Corrective Lenses • Patch	☐	☐	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_____

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 _____

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

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 neuropsychiatric 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 _____

Address _____ Phone _____

Signature of physician, APN, PA _____

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 _____

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_____

Audubon Public Schools

350 Edgewood Avenue, Audubon, New Jersey 08106-1545
Phone (856) 547-7695 • Fax (856) 546-8550
www.audubonschools.org

RELEASE FOR STUDENT RECORDS/VERBAL INFORMATION

_____ _____ _____ _____
Student's Last Name **First Name** **Middle Name** **Suffix**

D.O.B.: _____

School Last Attended: _____**Grade Last Attended**_____

Address _____
Bldg.# *Street* *City* *State* *Zip Code*

Tel. No. ( ) _____ **Fax No.** ( ) _____

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

- ☐ Official Transcript
- ☐ Standardized Test Records
- ☐ Health Records
- ☐ Others_____
- ☐ State Issued ID (**SID #**)
- ☐ Disciplinary Records
- ☐ **Special Education & Related Services Records**

To the school / office checked below:

☐ **HAVILAND AVENUE ELEM. SCHOOL**
240 South Haviland Avenue
Audubon, NJ 08106
Phone: 856-546-4922
Fax: 856-547-1248

☐ **MANSION AVENUE ELEM. SCHOOL**
300 Mansion Avenue
Audubon, NJ 08106
Phone: 856-546-4926
Fax: 856-547-1483

☐ **JR/SR HIGH SCHOOL**
350 Edgewood Ave.
Audubon, NJ 08106
Phone: 856-547-7695
Fax: 856-547-1901

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
- Speech Therapy
- Occupational Therapy
- Physical Therapy
- Psychological Counseling
- Audiology
- Nursing
- 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.