

TOTOWA BOROUGH PUBLIC SCHOOLS

Office of Curriculum & Instruction

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www.totowa.k12.nj.us

Patricia Capitelli

Chief School Administrator

Beverly Luciano

School Nurse

June 16, 2020

Dear Parents / Guardians:

The Totowa Public Schools are requiring a re-verification process for all students entering into 3rd grade and 6th grade. This new process is to help keep the students medical records up to date.

The re-verification process requires the completion and submission of the attached forms, and a complete vaccination record. The specific supporting document forms can be found at our website:

www.totowa.k12.nj.us under **Nurses Corner** or on the parent portal. Families are required to send this information to the Nurse's office via mail or email.

Please be advised, your re-verification forms and supporting documents should be received by August 15, 2020.

Thank you in advance for your cooperation during this process. If you have any questions, please feel free to call 973-956-0010 ext. 2200.



Beverly Luciano

School Nurse, MS, BSN, RN, CSN

TOTOWA SCHOOLS PHYSICAL EXAM REPORT

Child's Name: _____ Sex: _____ Birthdate: _____

Father's Name: _____ Mother's Name: _____

Date of Physical: _____

Pulse _____ Resp. _____ B/P _____

Height _____ Weight _____

Eyes-Vision	Normal _____	Abnormal _____
Ears-Hearing	Normal _____	Abnormal _____
Nose-Throat	Normal _____	Abnormal _____
Lungs	Normal _____	Abnormal _____
Heart	Normal _____	Abnormal _____
Nutrition	Normal _____	Abnormal _____
Skeletal System	Normal _____	Abnormal _____
Skin	Normal _____	Abnormal _____
Nervous System	Normal _____	Abnormal _____

Disease History

Tuberculosis	Yes _____ - Date _____	No _____
Chicken Pox	Yes _____ - Date _____	No _____
Measles	Yes _____ - Date _____	No _____
AIDS	Yes _____ - Date _____	No _____
Scarlet Fever	Yes _____ - Date _____	No _____
Hepatitis	Yes _____ - Date _____	No _____
Lyme Disease	Yes _____ - Date _____	No _____

Scoliosis: >10 years old. Pos * ___ Neg ___ Explain* _____

Allergies that might affect school behavior or attendance _____

Describe any physical condition that might affect student's participation in the school program _____

Does this student take any medication on a regular basis? List medications _____

Has this student ever had a psychiatric exam? Identify reasons and results _____

Has this student ever had a neurological exam? Identify reason and results _____

Rate student's overall health: ___ Excellent ___ Good ___ Fair ___ Poor

*Signature of examining physician _____ Date: _____

***OFFICIAL PHYSICIAN STAMP:**

***(THIS FORM IS NOT ACCEPTED WITHOUT SIGNATURE & STAMP OF PHYSICIAN)**

HEALTH HISTORY

This questionnaire has been developed so that we might better understand your child and meet his/her individual needs. This questionnaire will be kept with your child's school medical records.

Child's Name: _____ Date of Birth: _____

Address: _____ Totowa, NJ Home Phone #: _____

Mother's Name: _____ Father's Name: _____

Child's Physician: _____ Physician Phone #: _____

1. How would you describe your child's general health? Excellent Good Fair Frequently ill
2. Has your child ever been hospitalized? Yes No
If yes, please describe the reason: _____

3. Has your child ever had a traumatic injury? (Head injury, broken bones, stitches) Yes No
If yes, please describe: _____

4. Were there any complications at birth? _____
5. Are there any family illnesses which might have an effect on your child? (Diabetes, etc.) _____

6. Has your child ever had an eye exam? _____. When and results: _____
7. Does your child wear glasses? Yes No
8. Has your child ever had a hearing exam? _____. If yes, results: _____
9. Does your child have any allergies? _____. What specific things is your child allergic to? _____

10. Has your child ever had a severe allergic reaction which requires that medication be kept in school?
 Yes No. If yes, explain: _____

11. Has your child ever had Chicken Pox disease? Yes No. If yes, date: _____
12. Has your child ever had the Chicken Pox vaccine (Varivax)? Yes No. If yes, date: _____
13. Please place a check mark next to any of the following medical problems your child has experienced:

<input type="checkbox"/> convulsions due to high fever	<input type="checkbox"/> headaches
<input type="checkbox"/> tonsillitis	<input type="checkbox"/> ear infections
<input type="checkbox"/> tonsillectomy	<input type="checkbox"/> perforated eardrum
<input type="checkbox"/> myringotomy	<input type="checkbox"/> fluid in middle ear
<input type="checkbox"/> cauterization of nose	<input type="checkbox"/> bloody nose
<input type="checkbox"/> strep throat	<input type="checkbox"/> asthma
<input type="checkbox"/> heart dysfunction	<input type="checkbox"/> bladder infection
<input type="checkbox"/> eczema	<input type="checkbox"/> turning in or out of feet
<input type="checkbox"/> hay fever	<input type="checkbox"/> arthritis
<input type="checkbox"/> congenital hip	<input type="checkbox"/> coordination difficulties
<input type="checkbox"/> hyperactivity (diagnosed by doctor)	<input type="checkbox"/> involuntary urination (day / night)

(PLEASE COMPLETE BOTH SIDES)

14. Please comment on any areas you have checked: _____

15. Does your child have any special fears or anxieties? _____. If yes, please explain: _____

16. Does your child take any medication on a regular basis? _____ Yes _____ No
Name of medication: _____ Dosage: _____
Prescribing Doctor: _____
Reason for this medication? _____

17. Any additional health/medical information about which we should be aware of? _____

**I GIVE MY PERMISSION TO HAVE THE INFORMATION CONTAINED IN THIS HEALTH HISTORY
SHARED
WITH THE MEMBERS OF THE SCHOOL STAFF WHO ARE RESPONSIBLE FOR MY CHILD.**

Parent/Guardian Signature

Date