TOTOWA BOROUGH PUBLIC SCHOOLS

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Patricia Capitelli
Chief School Administrator

Beverly Luciano
School Nurse

June 17, 2021

Dear Parents / Guardians:

The Totowa Public Schools are requiring a re-verification process for all students entering into 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, 2021.

Thank you in advance for your cooperation during this process. If you have any questions, please feel free to contact me via email.

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)***

PE EXAM REPORT 10/05

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:

______ convulsions due to high fever
______ tonsillitis
______ tonsillectomy
______ myringotomy
______ cauterization of nose
______ strep throat
______ heart dysfunction
______ eczema
______ hay fever
______ congenital hip
______ hyperactivity (diagnosed by doctor)
______ headaches
______ ear infections
______ perforated eardrum
______ fluid in middle ear
______ bloody nose
______ asthma
______ bladder infection
______ turning in or out of feet
______ arthritis
______ coordination difficulties
______ 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