

LOWER CAPE MAY REGIONAL SCHOOL DISTRICT
687 ROUTE 9 - CAPE MAY, NJ 08204
(609) 884-3475

2011-12

Date: August 1, 2011

Dear Parent/Guardian:

Welcome to the new school year. Hopefully it will be a healthy one for your child.

MEDICATION POLICY: Prescribed medication must be in a labeled prescription bottle with a note from the doctor stating name of medication, amount to be given, and time it is to be given. You must also return the enclosed permission form signed by the parent/guardian.

For over-the-counter medication such as Tylenol or Ibuprofen, etc. please return the enclosed permission form signed by a parent/guardian.

ABSOLUTELY NO MEDICATION WILL BE GIVEN WITHOUT WRITTEN PERMISSION.

GYM EXCUSE POLICY: You must supply a physician's note stating length of exclusion, reason for exclusion and day Physical Education may be resumed.

EMERGENCY NUMBERS: We cannot keep a sick child in the nurse's office for the entire day. Please make arrangements now to have someone we can reach in case your child is ill. Please return the enclosed emergency information form to the nurse's office.

IF A CHILD NEEDS TO BE SENT HOME, THE NURSE WILL PERSONALLY TELEPHONE YOU. IF A STUDENT CALLS AND ASKS TO COME HOME, IT WILL NOT BE ACCOUNTED FOR BY THE NURSE.

IMMUNIZATIONS: Please send in a written confirmation when your child receives a vaccination so we can update his/her health card. If you have not already done so, please return the enclosed permission form for your child's immunizations to be added to the NJ State Immunization database.

Thank you for your cooperation. If you have any questions, please call me at 884-3475, Ext. 238.

Sincerely,

Bonnie Walker, School Nurse

PLEASE NOTE: If your child is absent, please call the **SCHOOL ATTENDANCE OFFICER** (Ext. 268) between 8:00 A.M. and 9:00 A.M. to verify the absence.

PLEASE RETURN TO NURSE'S OFFICE.

LOWER CAPE MAY REGIONAL SCHOOL DISTRICT

687 ROUTE 9 – CAPE MAY NJ 08204

609-884-3475

2011-12

Student's Name _____ ID# _____ Birthdate _____ Grade _____

Current Address _____
Street _____ City _____ Home Phone _____

To Parent or Guardian: To serve your child in case of accident or sudden illness, it is necessary that you give the following information for emergency calls:

Mother/Guardian _____ Home Address/Phone _____
Work Address/Phone _____
Cell Phone _____

Father/Guardian _____ Home Address/Phone _____
Work Address/Phone _____
Cell Phone _____

List two neighbors or nearby relatives who will assume temporary care of your child if you cannot be reached:

Name _____	Name _____
Home Address _____	Home Address _____
Work Address _____	Work Address _____
Phone: Home _____	Phone: Home _____
Relationship _____	Relationship _____
Work _____	Work _____

SEE OTHER SIDE

Does child have health insurance:

Yes _____ If Yes, name of insurance company _____
No _____ NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information call 800-701-0710 or visit www.njfamilycare.org to apply online.

Cape Community Health Center's brochure is enclosed for those who have no health insurance.

List any medical/surgical care your child has received during the past year:

Allergy: Kind: _____ Medications: _____
Allergic Reaction: _____ Medications: _____

Restrictions: Type: _____

Doctor _____ Phone _____
Dentist _____ Phone _____
Hospital _____ Address _____ Phone _____

I, the undersigned, do hereby authorize officials of New Jersey Public Schools to contact directly the persons named on this card and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of said child.

In the event that physicians, other persons named on this card, or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child.

I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

Signature of Parent(s)/Guardian(s) _____ Date: _____

YOUR
NEIGHBORHOOD
HEALTH CENTER

Welcome!

No insurance? No problem.

- Medicaid • Medicare Accepted
- Financial Counselors Available
- We'll help you apply for public health insurance
- Qualify for reduced fees based on income

CAPE
COMMUNITY
HEALTH CENTER

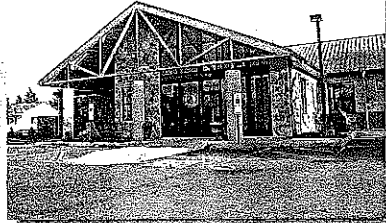
Call for an appointment:
(609) 465-0258



Certification by the Joint Commission
on Accreditation of Healthcare Organizations

Complete
Affordable Healthcare
for the Whole Family

CAPE
COMMUNITY
HEALTH CENTER



Ella Coker,
Center Manager

410 RT. 9 NORTH
CAPE MAY COURT HOUSE NJ
08210

FOR AN APPOINTMENT
PLEASE CALL:

(609) 465-0258
CAPE MAY COURT HOUSE
OFFICE

(856) 451-4700
MAIN OFFICE

CAPE

COMMUNITY HEALTH CENTER

410 RT. 9 N., CAPE MAY COURT HOUSE NJ, 08210



Complete
Affordable Healthcare
for the Whole Family

with
Cape Women's Health Care

Cape Community Health Center



COMPREHENSIVE CARE
FOR THE WHOLE FAMILY

- Board Certified Physicians, Nurse Practitioners and Certified Nurse Mid Wife
- Family Medicine/medical care for adults & children
- Pediatric care for children

OB/GYN/FAMILY PLANNING AND
WELL WOMEN'S HEALTH CENTER

OTHER SPECIALTY CARE ON SITE
OR THROUGH REFERRAL

- Podiatry
- Cardiology
- Gastroenterology
- Infectious disease



PREVENTIVE CARE

- Child & adult immunizations
- Well baby child care
- Employment, school, sports physicals
- Routine check-ups
- Periodic breast exams/ mammogram referral
- Diabetes management & education

SCREENINGS

- Blood Pressure • Cholesterol • Vision
- Hearing • Pregnancy tests
- HIV testing/counseling • Prostate exams



Centro de Salud

bilingual
staff



FAMILY DENTAL SERVICES

- Examination
- X-ray
- Restorative dentistry
- Cleaning & whitening
- Preventive dentistry
- Sealants, fluoride application
- Special school & day care group dental services

FEDERAL
PRESCRIPTION
PROGRAM



Absolute lowest pricing
on prescription drugs

SU CENTRO MÉDICO EN
SU VECINDARIO



¡Bienvenido!

¿No tiene seguros?
No hay problema.

- Asesores financieros a su disposición
- Ofrecemos seguros médicos públicos
- Califique para cuotas reducidos según sus ingresos

ACEPTAMOS:

- Medicaid • Medicare
- Se aceptan pacientes sin seguro

¿No tiene una cita? No hay problema.

- Se aceptan visitas sin citas

CENTRO MÉDICO
CAPE COMMUNITY

HORARIOS:

8:00 a.m. - 4:30 p.m.

de Lunes a Viernes

Para una cita llame al:

(609) 465-0258

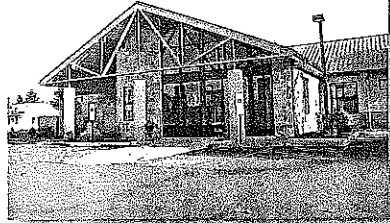


Certification by the Joint Commission
on Accreditation of Healthcare Organizations

Atención Médica
Total, Económica
Para Toda La Familia

Su Salud Es
Nuestro Compromiso

CENTRO MÉDICO
CAPE COMMUNITY



Ella Coker,
Administrador de
Oficinas

410 RT. 9 NORTH
CAPE MAY COURT HOUSE NJ
08210

PARA UNA CITA LLAME AL:

(609) 465-0258

OFICINA DE

CAPE MAY COURT HOUSE

(856) 451-4700

OFICINA PRINCIPAL

CENTRO MÉDICO
CAPE COMMUNITY

410 ROUTE 9 NORTH
CAPE MAY COURT HOUSE NJ 08210



Atención Médica
Total, Económica Para
Toda La Familia

con
Cape Cuidado de Salud
Para Mujeres

Cape Community Health Center



CUIDADO COMPRESIBO
PARA TODA LA FAMILIA

- Médicos Certificados por la junta de médicos
- Enfermeras Calificadas y enfermeras certificadas de parto
- Pediatría
- Medicina familiar/atención médica para niños y adultos

OBSTETRICIA/PLANIFICACIÓN DE FAMILIA
Y CENTRO DE SALUD PARA MUJERES

OTRAS ESPECIALIDADES EN ESTE
CENTRO O REFERIDOS:

- Podiatría
- Cardiología
- Gastrología
- Enfermedades infecciosas
- y otras especialidades

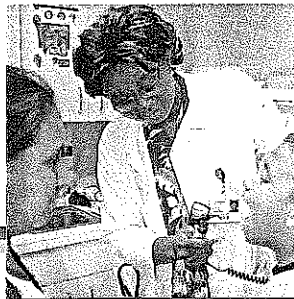


MEDICINA PREVENTIVA

- Vacunas para niños y adultos
- Exámenes para los niños
- Exámenes físicos ocupacionales, escolares, deportivos
- Exámenes mamarios preventivos/ mamografía
- Educación y control de la diabetes

PRUEBAS MEDICAS

- Presión arterial
- Colesterol
- Visión
- Audición
- Pruebas de embarazo
- Pruebas de CIDA
- Exámenes de próstata



Centro de Salud

bilingüe



SERVICIOS DENTALES FAMILIARES

- Examen
- Radiografía
- Restauración de los Dientes
- Limpieza y blanqueamiento
- Tratamiento Preventiva
- Selladores, aplicación de flúor
- Servicios Dentales de Grupo para Niños Y Escolares.

PROGRAMA FEDERAL DE FARMACIA

Los precios más bajos
en medicamentos



SALA DE EMERGENCIA
24 HORAS 7 DIAS A LA SEMANA
CENTRO MÉDICO REGIONAL DE SJ

RETURN TO NURSE'S OFFICE

LOWER CAPE MAY REGIONAL SCHOOL DISTRICT
REQUEST FOR PRESCRIBED MEDICATIONS
TO BE GIVEN AT SCHOOL

2011-12

I request the nurse to see that _____ Grade _____ ID# _____
(Name of Student)

receives the following medication _____
(Name of Medication)

prescribed by _____ for _____
(Name of doctor) (Reason/Illness)

(See attached doctor's note.)

The medication is to be given at _____ (and) _____
(Time) (Time)

on the following day(s) _____
(List days or length of time)

Side effects (as described by my doctor) may include:

Signature of Parent/Guardian

Date

*** Medication **MUST** be in the prescription bottle and **BE KEPT** in the nurse's office.

➤ **ABSOLUTELY NO MEDICATIONS WILL BE GIVEN WITHOUT WRITTEN PERMISSION.**

RETURN TO NURSE'S OFFICE

LOWER CAPE MAY REGIONAL SCHOOL DISTRICT
687 RT. 9, CAPE MAY, NJ 08204
609-884-3475

High School
Joseph Castellucci, Principal
Bonnie Walker, RN, School Nurse Ext.238

Teitelman School
Gene Sole, Principal
Roseanne Casiello, School Nurse Ext. 275

PARENT NOTIFICATION OF SCOLIOSIS SCREENING

2011-12

Date: August 1, 2011

Dear Parent/Guardian:

There will be a screening program for scoliosis for pupils in **Grades 8, 10 and 12**, as required by law, which will be carried out over the current school year.

Scoliosis is defined as a condition of the spine in which the spine may curve to the left or right. It is most commonly found during the time of rapid growth and may progress if not treated. The purpose of the screening program is to recognize scoliosis in its earliest stages.

Pupils will be screened during a gym or health class depending on their schedule. A pupil may be exempted from this examination if requested by the parent/guardian in writing.

You are also invited to be present if you desire. However, females will be screened by the nurse or a female gym teacher. You will need to complete the form below so that you can be advised of the time to be present.

Whether you are present or not, you will be informed of any suspect problem.

Thank you for your cooperation.

Bonnie Walker, School Nurse

Roseanne Casiello, School Nurse

Name of Pupil: _____ Grade _____ ID# _____

_____ Please EXAMINE my child.

_____ Please EXCUSE/EXEMPT my child.

_____ I WILL COME TO THE SCHOOL TO WATCH THE SCREENING. Please call me at (phone#) _____ to MAKE AN APPOINTMENT to come to the school.

DATE: _____

Signature of Parent/Guardian

IF YOUR CHILD **HAS NOT ALREADY BEEN REGISTERED**, PLEASE RETURN THIS FORM TO THE NURSE'S OFFICE.

New Jersey Department of Health and Senior Services
 Vaccine Preventable Disease Program
 P.O. Box 369, Trenton, NJ 08625-0369
 609-588-7512 (Fax 609-588-3642)
 www.njiis.nj.gov

**NEW JERSEY IMMUNIZATION INFORMATION SYSTEM (NJIIS)
 CONSENT TO PARTICIPATE**

- RETAIN A COPY OF THIS FORM IN THE MEDICAL RECORD -

REGISTRANT INFORMATION	PARENT/GUARDIAN INFORMATION (if NJIIS Registrant is a minor)
Registrant Name (<i>Print</i>)	Name (<i>Print</i>)
Date of Birth	Address
Country of Birth	City, State, Zip Code
Name of Primary Health Care Provider	Relationship to Registrant
<p>I have received information about the New Jersey Immunization Information System (NJIIS) and understand that the purpose of this program is to help remind me when my/my child's immunizations are due and to keep a central record of my/my child's immunization history.</p> <p>I understand that the medical information in the NJIIS may be shared with authorized health care providers, schools, licensed child care centers, colleges, public health agencies, health insurance companies, and others as permitted by New Jersey Law at N.J.S.A. 26:4-131 et seq. and rules at N.J.A.C. 8:57-3.</p> <p>I understand that I can get a copy of my/my child's record from my primary health care provider, my local health department, or the New Jersey Department of Health and Senior Services (NJDHSS). The NJDHSS may be contacted at the website or telephone number listed above.</p> <p>There is no cost to participate in this program.</p> <p><input type="checkbox"/> Yes, I would like to participate in this program.</p> <p><input type="checkbox"/> No, I do not want to participate in this program.</p>	
Signature of Registrant (or Parent/Guardian, IF Registrant under 18 Years of Age)	Date

Name of NJIIS Enrollment Site	Registry ID Number	Medical Record Number
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- RETAIN A COPY OF THIS FORM IN THE MEDICAL RECORD -

24-Hour coverage of STUDENT
ACCIDENT INSURANCE (With or Without a
Dental Benefit) is available for all students
at a low price.

The application forms can be
obtained in the school nurse's office.