THE CRAIG SCHOOL

SUMMER ACADEMY FORMS

All forms must be returned for each student applying to the summer academy.

The Craig School Summer Academy will be held at our high school campus located at
24 Changebridge Road, Montville, NJ.

THE CRAIG SCHOOL
LOWER SCHOOL • MIDDLE SCHOOL • HIGH SCHOOL
ADMINISTRATIVE OFFICE
10 Tower Hill Road • Mountain Lakes, NJ 07046 • 973-334-1234 • www.craigschool.org

OFFICE OF THE NURSE

Dear Parents,

Welcome to The Craig Summer Academy! We are pleased your student will be joining us and are looking forward to a productive session. So that our morning academic and afternoon enrichment programs run effectively and proficiently, **we require summer forms** be kept on record for each student and be completed as follows: Please return these forms by **June 1**.

#1 TRANSPORTATION form- needs to be completed for everyone

#2 SUMMER EMERGENCY form- needs to be completed for everyone (including current Craig students)

#3 AUTHORIZATION TO ADMINISTER MEDICATIONS-needs to be completed for any child if medication is to be administered-must be signed by parent and physician

#4 EMERGENCY PLAN FOR ALLERGIC REACTION-needs to be completed for any child who requires emergency medication (limited to EPI-PEN and/ or inhaler) for an allergic reaction

#5 AFTERNOON ENRICHMENT MEDICAL CLEARANCE -needs to be completed for any child who is NOT currently a Craig School student.

Please contact us if you have any questions, and return these forms ASAP and no later than the start of camp, to the main office.
Thank you.

Deborah Mershimer RN BSN CSN

High School Nurse
973-334-1234 x300
dmershimer@craigschool.org

Ellen Meisenbacher RN BSN CSN

Lower/Middle School Nurse
973-334-1234 x107
emeisenbacher@craigschool.org

THE CRAIG SCHOOL
LOWER SCHOOL • MIDDLE SCHOOL • HIGH SCHOOL
ADMINISTRATIVE OFFICE
10 Tower Hill Road • Mountain Lakes, NJ 07046 • 973-334-1234 • www.craigschool.org

TRANSPORTATION INFORMATION SUMMER 2024

BUS COMPANIES/CAR POOLS

We are sure that you are aware of the importance of maintaining a current and accurate account of phone numbers should it become necessary to contact the bus companies or /other form of transportation. If any of the following information changes throughout the summer, please call the office or send a note.

Student's Name: .....

Age: ..... Grade: ..... Bus Co: .....

Other (Veh. description): .....

Address: .....

Phone: ( ) ..... Fax: ( ) .....

Contact Person: ..... Bus driver's cell phone: ( ) .....

Names of students in car pool: .....

.....

Car Pool driver's name: .....

Car Pool's driver cell phone: ( ) .....

Contact person (if bus or car pool unavailable): .....

Relationship to student: .....

Contact's Address: ..... Phone: ( ) .....

2 nd Contact: ..... Phone: ( ) .....

Date form completed: .....

FORM # 1

THE CRAIG SCHOOL
LOWER SCHOOL • MIDDLE SCHOOL • HIGH SCHOOL
ADMINISTRATIVE OFFICE
10 Tower Hill Road • Mountain Lakes, NJ 07046 • 973-334-1234 • www.craigschool.org

SUMMER EMERGENCY/ MEDICAL INFORMATION

Student's Name: .....

Student's age: ..... Student's grade: .....

Parent 1: ..... Parent 2: .....

Home Address: .....

Home Phone: ( ) ..... Email: .....

Parent 1-work phone: ( ) ..... Parent 2- work phone: ( ) .....

Parent 1- cell phone: ( ) ..... Parent 1- cell phone: ( ) .....

Contact person (if parent unavailable): .....

Relationship to student: .....

Contact's Address: ..... Phone: ( ) .....

2 nd Contact: ..... Phone: ( ) .....

Doctor's Name: ..... Phone: ( ) .....

Doctor's address: .....

Hospital affiliation: ..... Address: .....

List any and all prescription medication you give your child including dosage and time: .....

.....

.....

Allergies: .....

Other relevant information in case of emergency (e.g., past medical history): .....

Date of most recent physical exam: .....

If any information changes during the school year or summer program, please call the office or send a note.

In case of a medical emergency I will be called. In the event that a parent or guardian cannot be reached, I agree that The Craig School staff will make any medical decision deemed necessary. I agree to assume the financial responsibility for such treatment.

....

Signature of Parent/Guardian *Date* *Print Name*

NOTE: THIS FORM MUST BE COMPLETED FOR ALL STUDENTS AND RETURNED ASAP

FORM # 2

THE CRAIG SCHOOL
LOWER SCHOOL • MIDDLE SCHOOL • HIGH SCHOOL
ADMINISTRATIVE OFFICE
10 Tower Hill Road • Mountain Lakes, NJ 07046 • 973-334-1234 • www.craigschool.org

AUTHORIZATION TO ADMINISTER MEDICATIONS BY THE SCHOOL NURSE

New Jersey law requires a physician's written order and parent/guardian authorization for administration of any medication, prescription or over the counter. In order to administer any prescription medication to your child, The Craig School must have:

- Written authorization from the prescribing physician indicating the medication dosage and time of administration.
- Written authorization from the parent to administer medication

All medications must come to school in a clearly marked pharmacy container with the prescription label for your child. Unlabeled or incorrectly labeled containers and/or loose pills will be returned to the parent.

Any change in prescription during the school year or during the summer program must be accompanied by signed authorization from both parent and physician.

NAME OF STUDENT: .....

GRADE: ..... **DATE OF BIRTH:** .....

The following prescription/non-prescription medication(s) may be administered for the current school year (non-prescription may include e.g. Tylenol, Advil, Lozenges, Benadryl, Pepto-Bismol)

MEDICATIONS:

Dosage(s): .....

Time(s): .....

Reason for Medication: .....

MEDICATIONS:

Dosage(s): .....

Time(s): .....

Reason for Medication: .....

☐ ***I do not give permission for this student to receive over the counter medication***

....
Physician Signature *Physician Name (Please Print)* *Date*

AUTHORIZATION OF PARENT/GUARDIAN FOR THE SCHOOL NURSE TO ADMINISTER THE ABOVE MEDICATION(S)

I hereby authorize that the school nurse give my child the medication ordered by his/her physician.

....
Parent/Guardian Signature *Parent/Guardian Name (Please Print)* *Date*

FORM # 3

THE CRAIG SCHOOL
LOWER SCHOOL • MIDDLE SCHOOL • HIGH SCHOOL
ADMINISTRATIVE OFFICE
10 Tower Hill Road • Mountain Lakes, NJ 07046 • 973-334-1234 • www.craigschool.org

EMERGENCY PLAN FOR ALLERGIC REACTIONS

When School Nurse is absent and student is unable to self-administer EPI-PEN

NAME OF STUDENT: ..... DATE OF BIRTH: .....

ALLERGEN:

- If stung by an insect: .....
- After ingesting: .....
- After exposure to: .....

ACTION TO BE TAKEN BY CAREGIVER (Select with "X", as pertinent to student's procedure)

1. Monitor student for signs of Anaphylaxis for 30 minutes under direct observation.

Symptoms may include:

a. Sneezing, wheezing or coughing
b. Shortness of breath or tightness of chest; difficulty in or absence of breathing
c. Itching, with or without hives, raised red rash on any area of the body
d. Difficulty swallowing
e. Swelling of eyes, lips, face, tongue, throat or elsewhere
f. Hoarseness
g. Sweating or anxiety
h. Nausea, abdominal pain, vomiting & diarrhea
i. Dizziness and/or fainting
j. Involuntary bowel/bladder emptying
k. Sense of impending disaster or approaching death
l. Rapid or weak pulse
m. Skin flushing or extreme paleness
n. Burning sensation, especially face or chest
o. Blueness around lips, inside lips, eyelids
p. Loss of consciousness

2. When any of the above signs are present, caregiver should immediately give EPI-PEN according to the attached procedure:

Caregiver:

.....

.....

3. Call 911 for transport to hospital

4. Begin CPR for absent breathing/pulse

5. Scrape stinger away immediately, apply ice to sting bite

6. Notify parents

☐ ***DOES NOT APPLY***

..... *Physician Signature*

..... *Parent/Guardian Signature*

..... *Physician Telephone Number*

..... *Parent/Guardian Telephone Number*

..... *Date:*

FORM #4

..... *Parent/Guardian Telephone Number*

NJ State Universal Medical Form

This form should be completed by "New To The Craig School" Families Only.

UNIVERSAL CHILD HEALTH RECORD

ENDORSED BY:
American Academy of Pediatrics, New Jersey Chapter
New Jersey Academy of Family Physicians
New Jersey Department of Health

SECTION 1 - TO BE COMPLETED BY PARENT(S)

Child Name (Last) (First)	Gender ☐ Male ☐ Female	Date of Birth - -
Does Child have Health Insurance? ☐ Yes ☐ No	If Yes, Name of Child's Health Insurance Carrier	
Parent/Guardian Name	Home Telephone Number ( )	Work Telephone/Cell Phone Number ( )
Parent/Guardian Name	Home Telephone Number ( )	Work Telephone/Cell Phone Number ( )
I give my consent for my child's Health Care Provider & Child Care Provider/School Nurse to discuss the information on this form.		
Signature/Date	This from may be released to WIC. ☐ Yes ☐ No	

SECTION 1I - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:	Result of Physical Examination normal? ☐ Yes ☐ No	
Abnormalities Noted:	Weight (must be taken within 30days for WIC	
	Height (must be taken within 30days for WIC	
	Head Circumference (If <2 Years)	
	Blood Pressure (If >3 Years)	
IMMUNIZATIONS	☐ Immunization Record Attached ☐ Date Next Immunization Due:	

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐ None ☐ Special Care Plan Attached	Comments
Medications/Treatments • List Medications/Treatments:	☐ None ☐ Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitation/special considerations:	☐ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities:	☐ None ☐ Special Care Plan Attached	Comments
Allergies/Sensitivities • List Allergies/Sensitivities:	☐ None ☐ Special Care Plan Attached	Comments
Special Diet/Vitamin/Mineral Supplements • List Special Diet/Vitamin/Mineral Supplements:	☐ None ☐ Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagonosis • List behavioral/mental health issues/concerns:	☐ None ☐ Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed & the sign/symptoms to watch for:	☐ None ☐ Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: ☐ Capillary ☐ Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

☐ ***I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, Including physical education and competitive contact sports, unless above.***

Name of Health care provider:	Signature/Date
	Health Care Provider Stamp:

CH-14 Jan 30 Distibution: Original Child Care Provider
Copy-Parent/Guardian Copy-Health-care Provider