

THE **CRAIG** SCHOOL

Summer Academy Forms

The due date for form submission is **June 1st**.

A complete set of forms must be submitted for each individual student who is applying .

Please send completed forms to our records department: records@craigschool.org

**The Craig School Summer Academy
will be held at our lower school campus located at:
15 Tower Hill Road, Mt. Lakes Campus.**



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:

#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 June 1st.**

Thank you.

Deborah Mershimer RN BSN CSN

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Ellen Meisenbacher RN BSN CSN

Lower/Middle School Nurse
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TRANSPORTATION INFORMATION SUMMER 2026

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:



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



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

.....
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 I - TO BE COMPLETED BY PARENT(S)			
Child Name (Last)	(First)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth - -
Does Child have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> 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 form may be released to WIC. <input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER	
Date of Physical Examination:	Result of Physical Examination normal? <input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Immunization Record Attached <input type="checkbox"/> Date Next Immunization Due:

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