BYRAM HEALTH OFFICES

Dear Parents/Guardians:

Attached is the Health Care Plan which helps us plan for the health needs of your child at school and school related activities. This plan must be submitted each school year. We would appreciate your prompt return of the completed plan to the Health Office.

Please ask your physician to review and sign the care plan after you complete it. Include one picture of your child on the care plan and, if your child is to receive medicine at school, one picture on the medication.

Medications required at school or during school activities will be administered according to school policy. The policy is available on the school calendar and web site under Health Services, Medication. .

Please contact your school nurse to arrange for a meeting to discuss your child's special needs at school so that they can be put in place at the start of school. Messages can be left with the school secretaries or e-mails can be sent during the summer.

Please follow the medication policy that is sent home in September, on the school web site, and is also in the school calendar. Teachers and coaches cannot give medications. If your child needs to carry an inhaler or EpiPen for emergency use, please call your school nurse for more information.

We look forward to helping your child have a successful school year and please do not hesitate to call your school nurse for any questions or concerns. We have found that good communication really is a key to success.

Sincerely yours,

Intermediate School Nurse
973-347-1047 ex. 2103

Barbara Scholl, School Nurse
Byram Lakes Elementary
973-347-1019 ex. 2404

HEALTH CARE & EMERGENCY PLAN

Place Picture Here

Student's Name: _____

Grade: _____ Teacher: _____

Other information: **SEE EMERGENCY CARD**

Health Needs Information:

Health Need: _____

_____

Trigger/Cause of Need (bee sting, food intake, upper respiratory infection (cold), etc.)

_____

Signs and Symptoms of Health Need: _____

_____

List medications while at school:_____

_____

_____

_____

_____

Treatments and Special Equipment needed:_____

_____

Any Additional Accommodations needed:

_____

_____

Health Needs Plan

Please explain what your child's health needs will be for school and related activities, i.e. classroom, lunch, recess, trips, after school activities, sports, bus to and from school.

_____

_____

Bus # to School_____ Bus # from school_____

EMERGENCY PLAN

If my child has an emergency, it will be_____

_____

Do the following_____

_____

See Emergency card for necessary contacts and phone #s

PARENTAL PERMISSION TO SHARE CHILD'S HEALTH NEEDS

I have provided this information to plan for the health needs of my child at school and all related school activities and on the school bus.

I give permission for this information to be shared with the school staff, cafeteria staff and bus drivers who will be with my child during the school day.

Parent Signature_____

Physician Review: I have reviewed and agree with this School Health Needs Plan for _____. Additional Comments_____

_____

Physician Signature/Date_____

MEDICATIONS TO BE ADMINISTERED AT SCHOOL
BYRAM TOWNSHIP SCHOOLS
MEDICATION AUTHORIZATION FORM

DATE_____ SCHOOL_____

To be completed by PARENT/GUARDIAN:
I give permission for (name of student)_____Grade_____
to receive medication at school according to standard school policy. I understand that the medication must be delivered to the nurse in the original pharmacy container, with the student's name on it. I understand coaches and advisors cannot give medications. I will contact the nurse if there is a change in the medication or dosage.

Date	Parent/Guardian Signature	Home Phone

To be completed by PHYSICIAN:

1. Diagnosis for which medication is prescribed_____
2. Name of medication_____
3. Dosage_____tablet/capsule_____liquid_____inhaler_____other_____
4. Time to be administered by school nurse_____
5. Time and dosage when medication is given at home_____
6. Describe indication for "PRN" medication is to be given_____
7. How soon can the medication be repeated_____
8. Restrictions and/or important side effects: NONE ANTICIPATED_____YES_____
   _____
9. How long has the student been taking this medication_____
10. Other information/comments_____

Physician's Signature	Date
Physician's Stamp	Phone