



Pennsville Public School District

30 Church Street, Pennsville, NJ 08070-2199

Michael Brodzik, Ed.D.
Superintendent

Office (856) 540-6200
Fax (856) 678-7565

Dear Parent/Guardian:

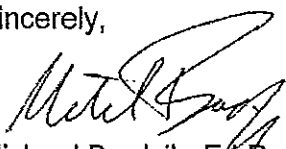
In the Pennsville School District, we strive to protect the well-being of our students, especially those with special health problems. This includes assisting teachers, students, and administrators to adapt to a student's health problems. Because of this commitment, it is important that certain confidential information about the student's health problem be shared by parents or guardians. This information will be used to plan for the care and management of the student when in school or participating in school activities.

If your child has a chronic health problem or a health condition that may create a need for emergency or supportive care during the school day, please complete the attached form. The school nurse is available to assist you in completing the form or answering any questions that you may have concerning the use of the information requested. Not all questions may apply to your child's specific problem.

Upon receiving a completed and signed form, the school nurse will contact the person completing the form to review or confirm the information before preparing an individualized emergency medical plan for the student. When necessary, the school nurse will provide in-service programs for teachers regarding the health condition and the specific emergency procedures that may need to be initiated at school.

It is important that you notify the school nurse during the school year of any changes in your child's health status, medications, treatments, or physician so that your student's emergency plan can be changed as needed. Your child's progress in school will be monitored and regular reports will be sent to you. Parent-school communication is vital to the success of the program and the safety of our students.

Sincerely,


Michael Brodzik, Ed.D.
Superintendent of Schools

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Attachments

Pennsville Public School District

30 Church Street, Pennsville, NJ 08070-2199

Office (856)540-6210

Fax (856)678-7565

INDIVIDUALIZED EMERGENCY CARE PLAN

Date: _____

Student's Name: _____ Sex: _____ Birth Date: _____

Primary Physician's Name: _____ Phone #: _____

Hospital Usually Treated: _____ Phone #: _____

Other Physician's Names:

1. _____ Phone #: _____

2. _____ Phone #: _____

3. _____ Phone #: _____

Presenting Problem Information:

Allergies: _____

Medications: _____

If applicable check the appropriate disorder:

<u>Feeding Disorders:</u>	Cleft lip/palate _____	Dysphagia _____
	Gastroesophageal reflux _____	Cranial nerve palsies IX, X, XII _____
	Tracheoesophageal/fistula _____	Esophageal atresia _____
	Other (please list) _____	

Emergency Plan:

Physician

School Nurse

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INDIVIDUALIZED EMERGENCY MEDICAL PLAN (IEMP)

Student's Name: _____ Sex: _____ Birth Date: _____

Mother's/Guardian's Name: _____ Daytime Telephone: _____

Father's/Guardian's Name: _____ Daytime Telephone: _____

Current health status of student with special health problem:
(to be completed by parent or guardian and student, when appropriate)

Student's primary diagnosis or presenting problem:

Student's primary care physician (not specialists):

Name: _____ Phone: _____

Address: _____

May the school nurse contact the physician in case there are questions or concerns in making an emergency care plan for your child? Yes _____ No _____

Does your child have allergies? Yes _____ No _____

If yes, what is he/she allergic to? _____

Please list below a step-by-step emergency plan for your child for each health problem. The school nurse is available to help you. (Use reverse side of page or separate sheet if you need additional space to list health problems.)

Health Problem

#1

Directions for an Emergency

- 1.
- 2.
- 3.
- 4.

#2

- 1.
- 2.
- 3.
- 4.

INDIVIDUALIZED EMERGENCY MEDICAL PLAN (IEMP)

Is your child prone to getting any particular health problems on a regular basis?

Yes ____ No ____

Is there a special way your child behaves when he/she is ill or about to become ill?

Yes ____ No ____

Please list all medications that your child is currently taking and the physician prescribing each one.

Medication	How Often	Health Problem	Doctor
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

Please list specialists, clinics, therapists, or other physicians consulted for your child, the problems involved, and the dates of the most recent exam.

MD or Other Specialist	Problem	Date Last Visited
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

May the school nurse contact any of the above listed health professionals in the event of a concern or a question? Yes ____ No ____

Comments or explanations of answers to any of the questions on this form:

Parent's/Guardian's Signature

Date