Welcome to St. Joseph’s School for the Blind. The staff and I want to make your child’s experience here a very successful one. However in order to begin to provide our comprehensive programming to your child, as well as, assuring his/her health and safety, you will need to submit the necessary documentation. Below is a list of those school forms and medical forms that will need to be submitted prior to your child starting school. These forms can be found in this packet.

**Required:** Your child’s physician must complete the following:

- **Annual Medical Review (M-1)**
- Immunization Update - please attach to (M-1)
- Prescription Medication – Authorization to administer (M-2)

**Strongly Recommended:**

- Eye Examination Report (M-3)
- Dental Examination (M-4)

**Required:** To be completed by parents/guardians:

- Parental/Guardian Authorization (M-5)
- Emergency Information (M-6)
- Authorization for emergency treatment (M-7)
- Student Medical File (M-8)
- Food Nutrition (M-9)

Your cooperation is appreciated. If you have any questions or concerns pertaining to these forms, please contact our school nurse, Theresa Hall, at (201) 876-5432 ext. 2111. Again, I would like to thank you and welcome you and your child to St. Joseph’s School for the Blind.

Sincerely,

Anthony R. Lentine, Jr.

Anthony R. Lentine, Jr., Ed.D.
Annual Medical Review

Name of Student: ____________________________________  School Year:____________________

Dear Doctor,

Please provide the appropriate test and immunizations to your patient, so that they do not risk losing time from school.

Immunizations (Please attach a copy of an updated immunization record)

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Date Given</th>
<th>Doctor’s Name</th>
<th>Date Next Dose Due</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Students entering for the first time are required to have a Mantoux.*

**History**

1. Indicate any known communicable diseases:

____________________________________________________________________________

____________________________________________________________________________

2. Previous Hospitalizations or surgeries:

____________________________________________________________________________

____________________________________________________________________________

3. Any significant changes in the child’s general Health since last exam?

____________________________________________________________________________

____________________________________________________________________________

**A. Clinical Examination**

1. Height: _____  Weight:_____  Temp:_____  Pulse:____  Resp:_____  B.P.:_____

2. Vision: ___________________ Structure of eyes: _____________________

3. Hearing: __________________ Structure of ears: ____________________

4. Does child wear hearing aids:______ Date of last hearing test:___________

5. Tonsils and adenoids: _____Normal _____Enlarged _____Removed _____ Interference w/ Response

6. Teeth and Gums: _______________________________________________________

7. Neck:________________________________________________________________

8. Lymphatic System: _____________________________________________________

9. Respiratory System: ___________________________________________________
Annual Medical Review

Name of Student: ____________________________________ School Year: __________________

10. Cardiovascular System: ____________________________________________________________
11. Gastrointestinal System: __________________________________________________________
12. Genitourinary System: ____________________________________________________________
13. Muscular System: _________________________________________________________________
14. Skeletal System: _________________________________________________________________
   What is his/her posture? ____________________ Physical Development? ______________________
15. Neurological System: _____________________________________________________________

B. Other Medical Conditions/Needs:

1. Seizures: _____Yes _____No
   If “yes” Please indicate frequency and type, if known: __________________________________
2. Special Dietary Needs: _____Yes _____No (attach prescriptions for special orders)
3. Allergies, sensitivities to food, drugs or others: ______________________________________
4. Mental Health Problems (Behavioral/Psychiatric Disorders): ____________________________
   ________________________________________________________________________________

C. Additional Information/recommendations:
   ________________________________________________________________________________
   ________________________________________________________________________________
   ________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

Physician’s Printed Name __________________________________________ Date of Examination ____________

__________________________________________________________________________________

Physician’s Signature

Physician’s Address: _________________________________________________________________

Physician’s Office Phone #: _________________________________________________________

Physician’s Email: _________________________________________________________________
Prescription Medication Authorization to Administer

Date: _____________

Name of Student:_________________________________ Birth Date: ___________________

I, ________________, hereby authorize appropriate school personnel to administer prescribed medication(s) to ________________.

Prescriptions (Rx) must contain student’s name, date, name of medication, dosage amount, and exact times to be taken. It must be signed by the physician with the doctor’s license number. All Rx’s must be written on a prescription pad and attached to this form.

___________________________________  _________________________________________
Physician’s Signature                  Parent’s/Guardian’s signature

___________________________________  _________________________________________
Physician’s Printed Name               Parent’s/Guardian’s Printed Name

___________________________________  _________________________________________
Street Address                        Street Address

___________________________________  _________________________________________
City         State       Zip Code       City         State       Zip Code

____________________________________
Parent’s/Guardian’s Email
**Eye Exam Report**

Student's Name: ___________________________  Date of Birth: __________
Address: _________________________________  Home Phone: ____________
City: _______________ State: _______ Zip: ____________  Work Phone: ____________
Parent’s/Guardian’s Name(s)__________________________
Parent’s/Guardian’s E-mail: __________________________
Diagnosis of eye condition (Primary Cause of visual impairment) ____________________________
Age of Onset _________  History ________________________________

**Visual Acuity**

If the acuity cannot be measured, complete this box using Snellen Acuities or Snellen Equivalents or NLP, LP, HM, CF.

<table>
<thead>
<tr>
<th>Without Glasses</th>
<th>With Best Correction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Near</td>
<td>Distance</td>
</tr>
<tr>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td>L</td>
<td>L</td>
</tr>
</tbody>
</table>

Please check the appropriate estimate of visual functioning.

- [ ] Total Blindness
- [ ] Legal Blindness (20/200 with correction)
- [ ] 20/70 o.u. with correction
- [ ] Field loss of 20 degrees or more o.u.

**Visual Fields**

Visual Field R [ ] in degrees  Visual Field L [ ] in degrees

**Color Vision**

- [ ] Normal
- [ ] Abnormal

**Photophobia**

- [ ] Yes
- [ ] No

**Is the present eye condition:**

- [ ] Permanent
- [ ] Recurrent
- [ ] Improving
- [ ] EOG
- [ ] VER
- [ ] Progressive
- [ ] Communicable
- [ ] Can be improved
- [ ] ERG
- [ ] Visual Fields

**Has the student had eye surgery?**

- Yes ___ No ___

If yes, circle what type of surgery:
1) Cataract  2) Cornea  3) Retinal  4) Enucleation  5) Other

**Has any eye medication been prescribed?**

- Yes ___ No ___

If yes, state type, dosage

**Low Vision aids prescribed**

- Glasses [ ]
- Sunglasses [ ]
- Monocular [ ]
- Other __________________

**Are there any physical restrictions or limitations in participating in school activities?**

- Yes ___ No ___

If yes, explain__________________________________________________

**Type of examination**

- [ ] Initial visit
- [ ] six month evaluation
- [ ] yearly update

Reexamination needed in

- [ ] 1 year
- [ ] 2 year
- [ ] 3 Years

**Print or Type name of Licensed Ophthalmologist**

________________________________________________

**Signature of Licensed Ophthalmologist**

________________________________________________

**Address**

________________________________________________

**Date of Examination:**__________________________

**City**  **State**  **Zip**

________________________________________________

**Telephone Number:**__________________________

Release of Information Parent Signature:__________________________
Dental Examination

Name of Student:_______________________________________  Date:____________________

Dear Doctor,

Your patient attends St. Joseph’s School for the Blind. Please complete the following:

This certifies that I have examined the above named student and:

___ All necessary dental work is completed.

___ Treatment is in progress.

Further recommendations include:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Dentist’s Signature  Date

Dentist’s Printed Name

Dentist’s Address:  
________________________________________________________________________
________________________________________________________________________

Phone Number:  
________________________________________________________________________
PARENTAL/GUARDIAN AUTHORIZATION

St. Joseph’s School for the Blind provides your child with a variety of services and experiences intended to enhance his/her educational program. Please sign below to indicate you have been informed of these services and, when indicated, that you consent to your child’s participation.

Name of Student: __________________________________________

I. AUTHORIZATION FOR CONSULTATION
The school contracts with consultants whose expertise enhances our educational programming. Consultants evaluate and/or work directly with our students and staff. Consultants may include Pediatricians, Pediatric Ophthalmologists, Audiologists, Nutritionists and other professionals.

I hereby give permission for consultants serving St. Joseph’s School for the Blind to evaluate and/or work with my child.

Parent’s/Guardian’s Signature __________________________________________ Date __________

II. SPECIAL ACTIVITIES INFORMATION
The school incorporates the following special activities in its educational, leisure, and recreational programs.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>
|     |    | Community field trips
|     |    | Swimming activities in our on-site swimming pool
|     |    | Instruction in hygiene, including tooth brushing, bathing, and grooming
|     |    | Use of photographic and recording devices, both audio and video, to develop evaluative data
|     |    | Community Based Instruction (CBI) and Structured Learning Experiences (SLE) Programs

Your signature indicates an understanding that the school incorporates these activities in programming.

Parent’s/Guardian’s Signature __________________________________________ Date __________

III. PUBLICITY/CONSENT RELEASE
St. Joseph’s School for the Blind sometimes participates in informational and educational publicity activities. Please read the “Authorization for Publicity Consent and Release” statement below and sign if such permission is granted. Permission is hereby given to use my dependent’s name, likeness, image, voice and/or appearance as such may be embodied in any pictures, photos, video recordings, audiotapes, digital images (e.g. Facebook, Twitter, Instagram), and the like, taken or made on behalf of St. Joseph’s School for the Blind. I agree that St. Joseph’s has complete ownership of such pictures, etc., including the entire copyright, and may use them for any purpose consistent with the School’s mission. These uses include, but are not limited to illustrations, bulletins, exhibitions, videotapes, reprints, reproductions, publications, advertisements and any promotional or education materials in any medium now known or later developed, including the internet. I acknowledge that I will not receive compensation, etc. for the use of such pictures, etc. and hereby release St. Joseph’s from any and all claims which arise out of or are in any way connected with such use.

I have read and understand the above and hereby give my consent to St. Joseph’s School for the Blind to use my dependent’s name and likeness to promote the program and/or their activities.

Parent’s/Guardian’s Signature __________________________________________ Date __________
AUTHORIZATION FOR EMERGENCY TREATMENT

In case of emergency, St. Joseph’s School for the Blind should notify my doctor:

Doctor’s Name:_____________________________________
Phone Number:____________________________________

Student’s Name:____________________________________

St. Joseph’s School for the Blind personnel have my permission to administer emergency first aid to my child or to bring him or her to the nearest medical facility for emergency care until I can be reached. I agree to pay any expenses incurred. My insurance company is:


I understand that every effort will be made to reach me.

Parent’s/Guardian’s Name:_____________________________________
Address:____________________________________________________
________________________________________________________________
Phone Number:________________________________________________
Parent’s/Guardian’s E-mail:______________________________________

Parent/Guardian Signature:______________________________________

This form must be witnessed by a Notary Public.

______________________________ (SEAL)
My Commission Expires:

Witnessed On: ________________________

M-7
STUDENT MEDICAL PROFILE

Student’s Name: _______________________________________________________________

Parent’s/Guardian’s Name: __________________________________________________________

Address: ____________________________________________   Home Phone Number: ______________

Cell Phone Number: ______________

Parent’s/Guardian’s Email: ______________________________________________________

Alternate Responsible Person: _______________________________________________________

Relationship: _____________ Home Phone Number: ______________ Cell Phone Number: ______________

Medical Information

Name of Attending Physician: ________________________________ Office Number: ______________

Name of Attending Dentist: ________________________________ Office Number ______________

Allergies to Medication or Food:
_______________________________________________________________________________
_____________________________________________________________________________________________
____________________________________________________________________________________

Diets
______________________________________________________________________________
_____________________________________________________________________________________________

Seizure Prone: _____Yes _____No   Date of Last Seizure: __________________________

Medications:___________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

Safety Equipment: ______________________ Hearing Aid: _____Left _____Right _____Both

Mobility Aids:
  V.P. Shunts: _____ Left _____Right
  Eye Prosthesis: _____ Left _____Right
  Prescription Glasses: _____ Left _____Right
  Date of Last PPD (Tuberculin) test: _________________________________
  Date of Last DT (Booster): _________________________________

Additional Medical Information or Comments:
_____________________________________________________________________________________________
_____________________________________________________________________________________________
Food and Nutrition Information for School

Please review your student’s current diet and liquid recommendations. Recommendations are for school lunch and for items brought from home. Direct questions or concerns to the school nurse at ext. 2111. Thank you.

Name Of Student: ___________________________________________________________

Date of Birth: __________________________________________

**FOOD TEXTURE (select one)**

- LEVEL 1 (pureed: pudding-like; No chewing skills required)
- LEVEL 2 (junior: moist, cohesive, soft; Minimal chewing skills required)
- LEVEL 3 (chopped: moist, bite-sized pieces; Moderate chewing skills required)
- LEVEL 4 (regular diet, No texture restrictions)

**LIQUID TEXTURE (select one)**

- HONEY THICK
- NECTAR THICK
- REGULAR (No Restrictions)

**FAMILY WILL SEND FOOD AND DRINK EVERYDAY**

Allergies: ________________________________________________________________

Intolerances: _____________________________________________________________

Special Needs: ____________________________________________________________

Parent/Guardian Signature ___________________________ Date _________________

Physician Signature _______________________________ Date _________________

Return this form to the School Nurse.

*Lunch, snacks, and beverages are integrated into the school day to provide nourishment, hydration, and social opportunities. Individual nutrition information including, prescribed diets, food textures, liquid consistencies and allergies/intolerances is an important part of each student’s record. These recommendations are made by the student’s physician, feeding team and/or family and may change during the school year.*