



The North Broward Preparatory School

April, 2009

Dear Parents,

Attached please find the ***Immunization Guidelines and Health Requirements for 2009/2010, Emergency Health Care Information Form, and the Authorization for Medication Form.*** A **new** Emergency Health Care Information Form must be submitted for each student, each new school year. All students entering Pre-Kindergarten through 12th grade must complete this form. It is important to take note that **this form must be signed and notarized.** For your convenience, notaries are available on all campuses. **A front and back copy of the student's health insurance and prescription card(s) must be submitted with the health form. The Emergency Health Care Information Form and the copy of the insurance card(s) should not be stapled together.**

Both the Emergency Health Care Information Form and the front and back copy of the student's health insurance card(s) must be returned **prior** to the first day of school. For your convenience, completed forms may be submitted before the end of the current school year. Hopefully, by making these forms available early, you will be able to eliminate last minute paperwork prior to the first day of school.

It is very important that all documentation be **current** for the duration of the school year. It is your responsibility to notify the school if any information changes. (Ex: home number/cell number, insurance carrier, doctors, etc.)

IMPORTANT: IF THIS FORM IS NOT ON FILE *BY THE FIRST DAY OF SCHOOL*, YOUR CHILD *WILL BE SENT HOME* AND WILL NOT BE PERMITTED TO RETURN UNTIL ALL NECESSARY DOCUMENTS ARE RECEIVED.

Please feel free to call or email Sandra Topal, R.N. at the Coral Springs campus (954) 752-3020, Ext. 720, topals@nbps.org; Patti Soliday, R.N. at the Coconut Creek Lower School campus (954) 941-4816, Ext. 114, solidayp@nbps.org, or Brooke Ferrer, L.P.N. at the Coconut Creek Upper School campus (954) 247-0011, Ext. 310, ferrerb@nbps.org should you have any questions.

Sincerely,

Sandra D. Topal, R.N.

Sandra D. Topal, R.N.
School Nurse-Coral Springs

Patti Soliday, R.N.

Patti Soliday, R.N.
School Nurse-Coconut Creek

Brooke Ferrer, L.P.N.

Brooke Ferrer, L.P.N.
Upper School Nurse-CC



North Broward Preparatory School
2009/2010 Immunization Guidelines and Health Requirements

- **Emergency Health Care Information Pre-K-12 Form (attached)** is required for all students in grade PreK-3 through 12. A new form **must** be submitted each school year. This form must be **SIGNED AND NOTARIZED**.
 - When filling out this form, please remember to be clear about allergies. Explain how your child reacts as well as how this reaction is managed. Be specific with food allergies and stings/bites. If your child requires an Epi-Pen, please have one available the first day of school. Place it in a zip lock bag with the child's name and grade visible. All medications must be brought directly to the nurse's office.
- **Health Insurance and Prescription Card(s)**: A front and back copy of the student's health insurance and prescription card(s) must be submitted along with the Emergency Health Care Information form. Please do **not** staple them together.
- **Immunization Form (Blue DH680 issued by your child's doctor's office)**:
 - In compliance with Florida law, each **NEW** student must submit proof of immunization on the blue form DH680 prior to the first day of school.
 - A new blue immunization form DH680 for **RETURNING** students is needed **only if your child has a newly recorded immunization. (All grades except 7th).**
 - In compliance with Florida state law, **all incoming 7th graders must submit a blue immunization form DH680 documenting the required TD booster and Varicella vaccine.**
 - Children entering, attending, or transferring to grades PreK, Gr. 2 through Gr. 8 in Florida schools are required to have **1** dose of Varicella vaccine. Children entering Kindergarten and Grade 1 will be required to have **2** doses of Varicella vaccine. Varicella vaccine is **not** required if the child has a history of Varicella (chickenpox). The physician must document the date of the disease on the immunization form along with a signature.
 - Students who are transferring to Florida schools from other states, or who are transferring to schools between Florida counties, shall be allowed up to a maximum of 30 days from the first day of school to submit proof of immunization. Proof of immunization must be on State of Florida Immunization Form DH680.
 - There is no exemption from immunization in Florida for personal or philosophical reasons. Requests for religious exemption must be submitted on a Department of Health Religious Exemption Form DH681, which will satisfy this requirement. **ONLY** county health departments issue form DH681.
 - 5th grade immunization records will be transferred to the Upper School campus with school records. The Emergency Health Care Information Form and imprint of the insurance card(s) should be returned to **the clinic at the Upper School** for students entering grades 6 through 12. The Emergency Health Care Information Form and imprint of the insurance card(s) for students entering PK-3 through 5 should be returned to **the clinic at the Lower School.**
- **Physical Examination Form (yellow form DH3040 issued by your child's doctor's office)**:
 - Florida law requires that each **NEW** student have a physical examination at least twelve months prior to entering school. Proof of examination is issued by the doctor's office on yellow form DH3040, which is to be submitted prior to the first day of school.
 - **RETURNING** students do not need documentation of a new physical examination unless requested to do so.
 - Students who are transferring to Florida schools from other states, or who are transferring to different schools between Florida counties shall be allowed up to a maximum of 30 days from the first day of school to submit proof of physical examination. Proof must be on State of Florida Form DH3040.
- **Authorization for Medication Form (attached)**:
 - Students requiring prescription medication during school must have an Authorization for Medication Form completed and signed by both **parent** and **physician**. Medication must be in a pharmacy container with proper labeling.
 - Students requiring "*over the counter*" medication during school must have an Authorization for Medication Form completed and signed by the **parent**. Medication must be brought to school in its original packaging.
 - Under **no** circumstances may a student carry or self-administer any type of medication, **except** Middle and High School students will be permitted to carry an Epi-Pen or an inhaler, if an Authorization for Medication form signed by a physician states the student may do so..
 - All medications must be kept in the nurse's office.

Additional forms are available at NBPS.org (Quicklinks to Documents and Forms).

Please feel free to call Sandra Topal, R.N. 954/752-3020, ext. 720; Patti Soliday, R.N. 954/941-4816, ext. 114 or Brooke Ferrer, L.P.N. 954/247-0011, ext. 310 should you have any questions.



The North Broward Preparatory School Emergency Health Care Information (Pre-K – 12)

Part 1. Student Information (to be completed by parent/guardian):

Student's Name: _____ SS#: _____ Sex: ____ Age: _____

Date of Birth: ____/____/____ Grade in School: _____

Sport(s): _____

Address: _____

Phone: (____) _____

Father/Guardian: _____ Home #: _____ Work #: _____ Cell #: _____

Beeper #: _____ Email: _____

Mother/Guardian: _____ Home #: _____ Work #: _____ Cell #: _____

Beeper #: _____ Email: _____

Person to Contact in Case of Emergency:

Relationship to Student: _____ Home Phone Number: (____) _____

Work Phone Number: (____) _____ Cell Phone Number: (____) _____

Personal/Family Physician: _____ City/State: _____

Office Phone: (____) _____ Dentist Name/Phone Number: _____

Health Insurance Co. & Policy #: _____ Phone # (____) _____

Part 2. Medical History (to be completed by parent/guardian). Explain "yes" answers below. Circle questions you don't know answers to.

	Yes	No
1. Have you had a medical illness or injury since your last checkup?	___	___
2. Do you have an ongoing chronic illness?	___	___
3. Have you ever been hospitalized overnight?	___	___
4. Have you ever had surgery?	___	___
5. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?	___	___
6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	___	___
7. Do you have any allergies (for example, to pollen, medicine, food, or Stinging insects)?	___	___
8. Have you ever had a rash or hives develop during or after exercise?	___	___
9. Have you ever passed out during or after exercise?	___	___
10. Have you ever been dizzy during or after exercise?	___	___
11. Have you ever had chest pain during or after exercise?	___	___
12. Do you get tired more quickly than your friends do during exercise?	___	___
13. Have you ever had racing of your heart or skipped heartbeats?	___	___
14. Have you had high blood pressure or high cholesterol?	___	___
15. Have you ever been told you have a heart murmur?	___	___
16. Has any family member or relative died of heart problems or sudden death before age 50?	___	___
17. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	___	___
18. Has a physician ever denied or restricted your participation in sports for any heart problems?	___	___
19. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	___	___
20. Have you ever had a head injury or concussion?	___	___
21. Have you ever been knocked out, become unconscious, or lost your memory?	___	___
22. Have you ever had a seizure?	___	___
23. Do you have frequent or severe headaches?	___	___
24. Have you ever had numbness or tingling in your arms, hands, legs, or feet?	___	___
25. Have you ever had a stinger, burner, or pinched nerve?	___	___
26. Have you ever become ill from exercising in the heat?	___	___

- 27. Do you cough, wheeze, or have trouble breathing during or after activity?
- 28. Do you have asthma?
- 29. Do you have seasonal allergies that require medical treatment?
- 30. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?
- 31. Have you had any problems with your eyes or vision?
- 32. Do you wear glasses, contacts, or protective eyewear?
- 33. Have you ever had a sprain, strain, or swelling after injury?
- 34. Have you broken or fractured any bones or dislocated any joints?
- 35. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?

If yes, check appropriate blank and explain below.

- | | | |
|------------------------------------|----------------------------------|------------------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> Elbow | <input type="checkbox"/> Hip |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Forearm | <input type="checkbox"/> Thigh |
| <input type="checkbox"/> Back | <input type="checkbox"/> Wrist | <input type="checkbox"/> Knee |
| <input type="checkbox"/> Chest | <input type="checkbox"/> Hand | <input type="checkbox"/> Shin/Calf |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> Finger | <input type="checkbox"/> Ankle |
| <input type="checkbox"/> Upper Arm | <input type="checkbox"/> Foot | |

- 36. Do you want to weigh more or less than you do now?
- 37. Do you lose weight regularly to meet weight requirements for your sport?
- 38. Do you feel stressed out?
- 39. Record the dates of your most recent immunizations (shots) for:
 Tetanus: _____ Measles: _____
 Hepatitis B: _____ Chickenpox: _____

FEMALES ONLY (optional)

- 40. When was your first menstrual period? _____
- 41. When was your most recent menstrual period? _____
- 42. How much time do you usually have from the start of one period to the start of another? _____
- 43. How many periods have you had in the last year? _____
- 44. What was the longest time between periods in the last year? _____

*** MAY TYLENOL/ADVIL/BENADRYL BE GIVEN? YES NO

Explain "Yes" answers here:

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Student: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

PERMISSION TO ADMINISTER EMERGENCY MEDICAL CARE/WAIVER OF RESPONSIBILITY AND PERMISSION:

I/WE, _____, hereby give permission for the above-named student to receive emergency medical treatment, including surgery, by a physician, hospital, or other provider of health care, in the event that the parent(s)/legal guardians(s) cannot be contacted. It is also understood that financial responsibility for medical treatment or services is that of the parent(s)/legal guardian(s) individually or through their family medical coverage. In consideration of the benefits to be derived, and in view of the fact The North Broward Preparatory School is an educational institution, in which enrollment is voluntary, and having full confidence that every precaution will be taken to insure safety and well being of my child, the above-named student, on the events, trips, and outings organized and sponsored by the School, I agree to his/her participation and waive all claims against the school, its employees, and representatives.

X _____
Signed: Father/Guardian

X _____
Signed: Mother/Guardian

STATE OF FLORIDA
COUNTY OF BROWARD

On this _____ day of _____, before me personally came _____ to me personally known and known to me to be the same person(s) described in and who executed the foregoing Permission of Administer Emergency Medical Care, and __he__ acknowledges to me that __he__ executed the same.

NOTARY

(Please note: Some hospitals require a notarized permission to administer emergency care.)



THE NORTH BROWARD PREPARATORY SCHOOL

AUTHORIZATION FOR MEDICATION

Name of Student: _____ Campus: ___ Coconut Creek ___ Coral Springs

Diagnosis

Date

Medication & Dosage Prescribed

Physician

Time & Direction for Administration by School Personnel

SIDE EFFECTS/SPECIAL INSTRUCTIONS:

Signature of Physician (Required for prescription medications)

Date

PARENTAL PERMISSION (to be completed by Parent or Guardian)

I grant the principal or his/her designee permission to assist in the administration of each prescribed medication to be provided during the school day, including when _____
is away from school property on official school business. student's name

SIGNATURE OF PARENT/GUARDIAN

DATE