

Registration Packet



ST. JOSEPH'S
SCHOOL FOR THE BLIND

761 Summit Avenue

Jersey City, New Jersey 07307

schoolfortheblind.org



St. Joseph's School for the Blind

Dr. Anthony R. Lentine, Jr., Principal

Welcome to Saint 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 you child, as well as, assuring his/her health and safety, you will need to submit the necessary documentations. Below is a list of those school forms and medical forms that will need to be submitted prior to your child starting school? These form 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) – **Note this form is required for our residential students.**

Required: To be completed by parents/guardians:

- _____ Parental/Guardian Authorization (M-5)
- _____ Emergency Information (M-6)
- _____ Authorization for emergency treatment (M-7) – **Note: 2 forms must be completed for our residential students.**
- _____ 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. 118. Again, I would like to thank you and welcome you and your child to Saint Joseph's School to the Blind.

Sincerely,

Anthony R. Lentine, Jr.

Anthony R. Lentine, Jr., Ed.D.

St. Joseph's School for the Blind



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(201) 876-5432/ Fax (201) 876-5430

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)

<u>Vaccine</u>	<u>Date Given</u>	<u>Doctor's Name</u>	<u>Date Next Dose Due</u>
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Residential students and students entering for the first time are required to have a Mantoux. Residential students are required to repeat Mantoux testing annually.

A. 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? _____

B. 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: _____

M-1

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: _____

C. 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): _____

D. Additional Information/recommendations: _____ _____ _____

Physician's Printed Name

Date of Examination

Physician's Signature

Physician's Address: _____

Physician's Office Phone #: _____

Physician's Email: _____



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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



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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 Acuties or Snellen Equivalentents or NLP, LP, HM, CF.

Without Glasses		With Best Correction	
Near	Distance	Near	Distance
R	R	R	R
L	L	L	L

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: _____



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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:



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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 and residential program:

Yes	No	
_____	_____	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

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 Concordia Learning Center to use my dependent's name and likeness to promote the program and/or their activities.

Parent's/Guardian's Signature

Date



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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 has 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:

Name of Insurance Company: _____

Billing Address: _____

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.

My Commission Expires:

(SEAL)

Witnessed On: _____



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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:



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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. 118. 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)

FAMILY WILL SEND FOOD AND DRINK EVERYDAY

LIQUID TEXTURE (select one)

HONEY THICK

NECTAR THICK

REGULAR (No Restrictions)

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.