Registration Packet

761 Summit Avenue

Jersey City, New Jersey 07307

schoolfortheblind.org

ST. JOSEPH'S
SCHOOL FOR THE BLIND

Early Intervention
In District Support Services
School for the Blind
Adult Services
Concordia Learning Center

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.

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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)

Vaccine	Date Given	Doctor's Name	Date Next Dose Due

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: _____

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: _____

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: _____

M-1

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

_____
Physician's Printed Name

_____
Street Address

_____
City State Zip Code

_____
Parent's/Guardian's signature

_____
Parent's/Guardian's Printed Name

_____
Street Address

_____
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 Acuities or Snellen Equivalents 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:_____

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, leisure, and recreational programs.

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
_____	_____	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

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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 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: _____

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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:

_____

_____

_____

M-8

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.