

Monmouth County Vocational School District

Charles R. Ford, J., Ed.D.
Superintendent

4000 Kozloski Road
PO Box 5033
Freehold, NJ 07728-5033
732-431-7942
fax 732-409-6736

Sean R. Meehan
Assistant Superintendent

Kelly A. Brazelton
*Business Administrator
Board Secretary*

FORM A

TO: Examining Physician/Laboratory

*This form must be returned to the School Nurse within 24 hours

MEDICAL INFORMATION RELEASE FORM

I, _____ give my permission to release information related to medical, psychological, social, psychiatric and substance use.

Information and all test results should be forwarded to the School Nurse at:

School: _____

Phone: _____

Fax: _____

Nurse: _____

Information is to be confidentially addressed or brought to the School Nurse at:

School: _____

Address: _____

Nurse: _____

Signature of Student: _____

Date: _____

Signature of Parent/Guardian: _____
(Required if Pupil is under 18 years of age)

Date: _____

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FORM B

TO: Examining Physician

CHEMICAL ASSESSMENT SCREENING

Student's Name: _____ Case #: _____

The following is a list of substances for which the above named student must have his/her blood and/or urine screened. **The chain of custody procedures must be observed.**

Amphetamines
Barbiturates
Benzodiazepines
Cocaine
Opiates
THC

Phencyclidine (PCP)

Ephedrine

Other Substances to test for: _____

Other substances may be added as warranted. The results of the screening should be forwarded as soon as possible. A release form shall be signed allowing these results to be reported directly to the School Nurse

School: _____

Address: _____

Phone: _____

Fax: _____

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FORM C

EXAMINING PHYSICIAN'S ASSESSMENT FORM

(must be completed and returned within 24 hours)

Student's Name: _____ Date of Birth: _____

Tests performed: _____

Date and Time of Tests: _____

I, _____ hereby certify that the above named student of Monmouth County Vocational School District is physically and mentally able to return to school and that no mood or mind-altering chemicals presently interferes with the student's physical or mental ability to perform in school.

Doctor's Name: (printed or typed) _____

Doctor's Address: _____

Doctor's Phone/Fax #: _____

Doctor's Signature: _____

Physician's Stamp: _____

It is suggested that physicians not trained specifically in adolescent chemical dependency contact the Medical Society of New Jersey, in Princeton, for advice in these matters.

***Student will not be readmitted to Monmouth County Vocational School District until this form has been completed by a physician and returned to the school district.**

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STUDENT ASSISTANCE COUNSELOR RECOMMENDATION FORM

FORM D

Your child has tested **positive** for the following substance/substances: _____

He/she **MUST** comply with our school policy:

1. _____ An outside assessment is required by a certified agency. This assessment will be scheduled within a week of this meeting. A suggested list will be provided at the meeting.
2. _____ Your child will follow the recommendations of the assessment and a letter indicating your child has started counseling will be given to the Student Assistance Counselor or the School Nurse.
3. _____ This counseling program will include weekly urine screens and a strong family component. Urine screen results will be provided to the Student Assistance Counselor/Nurse.
4. _____ A Records Release form (Form A) will be signed at the counseling program so that the Student Assistance Counselor will have contact with the therapist or case manager.
5. _____ Your child will meet with the Student Assistance Counselor on a regular basis.
6. _____ Your child will be subject to random urine screens after the counseling program is completed.
7. _____ Disciplinary actions will be assigned by the Principal or his designee if warranted.
8. _____ Failure to comply with these recommendations may result in an expulsion hearing and a referral to DYFS and/or police.
9. _____ Other _____

Additional Comments and Recommendations: _____

Recommendations for: _____ Date: _____

Student Signature: _____

Parent/Guardian Signature: _____

Others Attending: _____