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

Collette C. Flatt
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:______________________ Date:_____________________
(Required if Pupil is under 18 years of age)

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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: ____