SCHOOL	**GRADE**	**STUDENT NAME**

Failure to submit required health documentation will result in medical suspension.

Health Forms

The child's **parent/guardian** must complete & sign these forms.

All forms in this packet must be completed, signed & submitted to the **School Nurse** before **the first day of school**.

No Exceptions.

Failure to submit required health documentation will result in medical suspension.

Dear Parent/Guardian:

We are committed to the health and wellbeing of your child. In order to maintain the safety and wellbeing of your child, and all of our students, we need the forms in this packet to be **completed and returned to the School Nurse no later than the date printed on the cover of this packet.**

This packet contains material to be completed by you, as well as forms to be completed by your child's doctor.

If your child does not have a pediatrician, please contact the office of Dr. Kia Calhoun Grundy at 908.810.8551 or visit 2333 Morris Avenue, Suite B218 in Union.

Please verify that her office accepts your insurance plan.

If you have any questions regarding these forms or the Health Office procedures, or if you would like to speak to a School Nurse about your child's health issues, please contact the school.

As a resource, we have provided a schedule of immunizations your child should have at various points in his/her development (pages 15-16).

We look forward to providing excellent service to your child.

Best Regards,

The School Nurses

HEALTH FORM COMPLETION INSTRUCTIONS

SECTION 1 REQUIRED for ALL STUDENTS

PARENT/GUARDIAN must complete & sign the following forms:

Pages 2 through 6.

1	**Student Health Information & Release**	***PARENT/GUARDIAN:*** *Complete and sign*	**REQUIRED**
2	**Over-the-Counter Medication Permission**	***PARENT/GUARDIAN:*** *Complete and sign*	**REQUIRED**
3	**Medication Policy**	***PARENT/GUARDIAN:*** *Complete and sign*	**REQUIRED**
4	**Physical Evaluation History Form (2 sided)**	***PARENT/GUARDIAN:*** *Complete and sign*	**REQUIRED**

SECTION 2 REQUIRED FOR ALL STUDENTS

DOCTOR must complete & sign the following form:

Pages 7 through 8.

5	**Physical Examination Form (2 sided)**	***DOCTOR Completes and signs***	**REQUIRED**

SECTION 3 REQUIRED FOR SOME STUDENTS

Pages 9 through 14.

If the child has to take ***any medication during school hours or has asthma, allergies or seizures***, the appropriate forms listed below are required. All forms listed below must be signed by the doctor:

6	**Medication Administration Request**	***PARENT/GUARDIAN & DOCTOR*** *Completes*	***If applicable***
7	**Asthma Treatment Plan**	***PARENT/GUARDIAN & DOCTOR*** *Completes*	***If applicable***
8	**Allergy Action Plan**	***PARENT/GUARDIAN & DOCTOR*** *Completes*	***If applicable***
9	**Seizure Action Plan**	***PARENT/GUARDIAN & DOCTOR*** *Completes*	***If applicable***

PARENT/GUARDIAN: Please complete & sign this form.

STUDENT HEALTH INFORMATION & RELEASE

Section 1: GENERAL INFORMATION

Student's Name _____ Date of Birth _____

May the School Nurse contact the student's physician? ☐ Yes ☐ No

May health information be released to the School Nurse? ☐ Yes ☐ No

Does the student have health insurance? ☐ Yes ☐ No

If yes, what is the health insurance company's name, policy number, & primary policy holder's name?

_____	_____	_____
Insurance Company	Policy Number	Name of Primary Policy Holder

HOSPITAL PREFERENCE

☐ University Hospital (UMDNJ)

☐ Newark Beth Israel Medical Center

☐ Saint Michael's Medical Center ☐ Other _____

Section 2: ALLERGIES

FOOD ALLERGIES

Please list any allergies and/or sensitivities

examples: peanut butter, milk, eggs, shellfish, etc.

MEDICINES

Please list any allergies and/or sensitivities

examples: penicillin, insulin, etc.

BEE STINGS

Is the student allergic to bee stings?

☐ Yes ☐ No

POLLENS

Please list any allergies and/or sensitivities

examples: ragweed, mold, etc.

PARENT/GUARDIAN SIGNATURE

In the event a parent/guardian cannot be reached, I hereby give permission to TEAM Schools to obtain emergency medical treatment for the above-named child, including x-rays, and to release information pertaining to my child's health record, diagnosis, condition or health history, including any subsequent diagnosis which could supplement this form. This information may be released by a properly authorized representative of the school responsible for my child during periods of time when the school nurse is unavailable or when the student is away from the school building (i.e. during field trips).

_____	_____
Parent/Guardian Signature	Date

PARENT/GUARDIAN: Please complete & sign this form.

OVER-THE-COUNTER MEDICATION PERMISSION

Student's Name _____ Date of Birth _____

I hereby give permission to TEAM Schools to administer the medications listed below to the above named student, as designated in the TEAM Schools Medical Standing Orders issued by the school physician.

Routine First Aid	Non-routine First Aid
Saline eye wash	Tylenol or Ibuprofen (**ONLY** for a temperature of 100 or above)
Bacitracin	Benadryl (**ONLY** for allergic reactions)
Caladryl	Anbesol/Orajel
Vitamin A & D Ointment	
Sting kill wipes	
Bactine	
Burn gel	

I agree that TEAM Schools and its employees are not to be held liable for giving medicine in accordance with this Authorization. I agree to hold harmless and indemnify TEAM Schools and all of its employees against any and all claims, damages, expenses, attorney's fees, suits, cause or causes of action which may be brought against the network or its employees in connection with giving such medicine. This Authorization shall be effective unless revoked by me in writing. I intend to be legally bound by this Authorization.

_____ _____

Parent/Guardian Signature Date

MEDICATION POLICY

PRESCRIPTION MEDICATIONS

All medications are to be administered by the school nurse. In the absence of trained medical personnel a sub nurse should be called to administer medication to students. The school nurse will be the one to delegate, educate and train non medical staff on how to give **epinephrine only** for cases of severe allergic reactions.

In order for prescription medications to be given in school a written medication administration form must be completed by the physician that provides the name of the drug, dose, time it is to be taken and the diagnosis or reason the medication is needed. The use of the Asthma Action Plan is the form to be completed for all students who are asthmatic. These forms will need to be completed upon each new school year.

All prescription medications brought to school should be in their original container and appropriately labeled by the pharmacist. Parents must bring in and pick up all medications. No medications will be released to students unless given written permission to do so by the parent. All medications not picked up by the last day of school will be discarded.

OVER THE COUNTER MEDICATIONS

The only over the counter medications that will be provided by the school and administered in school will be acetaminophen or ibuprofen for temperatures over 100, Benadryl for allergic reactions and Anbesol/Orajel for tooth or mouth pain. Medications for these conditions will only be given if an over the counter medication form is signed by the parent or guardian and is on file in the health office. Over the counter medications are not to be brought in to school unless accompanied by a written note from their doctor and must be signed by parent/guardian.

No student is permitted to carry medication with them of any kind during the school day with the exception of asthma inhalers or epinephrine autoinjectors for severe allergic reactions. Students should still have a medication administration form on file and if possible back up medication in the health office. Physicians must also document that it is okay for student to carry own medication.

FIELD TRIPS

When on field trips a designated staff member will be trained in advance to administer **epinephrine and glucagon only**. If the parent is a chaperone then he or she will administer medication to his/her own child if needed. A trip book will also be provided of all students in that grade who are on medications. All medications with the exception of asthma inhalers and epinephrine auto injectors will be kept with the designee unless otherwise indicated.

HERBAL MEDICATIONS AND VITAMINS

These types of medications will not be given in school without written documentation from the physician and signed by the parents.

ROUTINE FIRST AID

The district doctor will provide standing orders on a yearly basis for routine first-aid treatments and emergency medications as well as over-the-counter routine items eyewash, Bacitracin, Caladryl, Vitamin A & D Ointment, Sting wipes, Bactine, Burn gel, Band-Aid Antiseptic wash which will be used for routine first aid needs.

OTHER GUIDELINES

It will be the parent's responsibility to supply the school with all prescribed medications and medical devices such as nebulizer tubing and mask, insulin syringes and needles. The school will provide the nebulizer.

All given medications should be documented on the daily medication log whether emergency or routine. If a student has an IEP medications given should also be logged into SEMI. Any errors in the administration of medications should be reported to the district doctor and Special Education Director so that corrective measures can be taken immediately.

_____ _____

Parent/Guardian Signature Date

ATTENTION PARENT/GUARDIAN: The preparticiaption physical examination (page 3) must be completed by a health care provider who has completed the Student-Athlete Cardiac Assessment Professional Development Module.

Physical Evaluation
HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep a copy of this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted the child's participation in sports for any reason?		
2. Does child have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____		
3. Has the child ever spent the night in the hospital?		
4. Has the child ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Has the child ever passed out or nearly passed out DURING or AFTER exercise?		
6. Has the child ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does the child's heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that the child has any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for the child's heart? (For example, ECG/EKG, echocardiogram)		
10. Does the child get lightheaded or feel more short of breath than expected during exercise?		
11. Has the chlid ever had an unexplained seizure?		
12. Does the child get more tired or short of breath more quickly than his/her friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in the child's family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in the child's family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in the child's family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Has the child ever had an injury to a bone, muscle, ligament, or tendon that caused the child to miss a practice or a game?		
18. Has the child ever had any broken or fractured bones or dislocated joints?		
19. Has the child had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Has the child ever had a stress fracture?		
21. Has the child ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Does the chlid egularly use a brace, orthotics, or other assistive device?		
23. Does the child have a bone, muscle, or joint injury that bothers him/her?		
24. Do any of the child's joints become painful, swollen, feel warm, or look red?		
25. Does the child have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Does the child cough, wheeze, or have difficulty breathing during or after exercise?		
27. Has the child ever used an inhaler or taken asthma medicine?		
28. Is there anyone in the child's family who has asthma?		
29. Was the child born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Does the child have groin pain or a painful bulge or hernia in the groin area?		
31. Has the chlid had infectious mononucleosis (mono) within the last month?		
32. Does the child have any rashes, pressure sores, or other skin problems?		
33. Has the chlid had a herpes or MRSA skin infection?		
34. Has the child ever had a head injury or concussion?		
35. Has the child ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Does the child have a history of seizure disorder?		
37. Does the chlid have headaches with exercise?		
38. Has the child ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling?		
39. Has the child ever been unable to move his/her arms or legs after being hit or falling?		
40. Has the child ever become ill while exercising in the heat?		
41. Does the child get frequent muscle cramps when exercising?		
42. Does the child or someone in your family have sickle cell trait or disease?		
43. Has the child had any problems with his/her eyes or vision?		
44. Has the child had any eye injuries?		
45. Does the child wear glasses or contact lenses?		
46. Does the child wear protective eyewear, such as goggles or a face shield?		
47. Does the child worry about his/her weight?		
48. Are you trying to or has anyone recommended that the child gain or lose weight?		
49. Is the child on a special diet or do you avoid certain types of foods?		
50. Has the child ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Has the child ever had a menstrual period?		
53. How old was the chlid when you had your first menstrual period?		
54. How many periods has the child had in the last 12 months?		

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 athlete _____ Signature of parent/guardian _____ Date _____

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New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

PARENT COMPLETES BOTH SIDES

Physical Evaluation

SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

1. Type of disability		
2. Date of disability		
3. Classification (if available)		
4. Cause of disability (birth, disease, accident/trauma, other)		
5. List the sports the child is interested in playing		
	Yes	**No**
6. Does the child regularly use a brace, assistive device, or prosthetic?		
7. Does the child use any special brace or assistive device for sports?		
8. Does the child have any rashes, pressure sores, or any other skin problems?		
9. Does the child have a hearing loss? Do you use a hearing aid?		
10. Does the child have a visual impairment?		
11. Does the child use any special devices for bowel or bladder function?		
12. Does the child have burning or discomfort when urinating?		
13. Has the child had autonomic dysreflexia?		
14. Has the chlid ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Does the child have muscle spasticity?		
16. Does the chlid have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

_____

_____

_____

_____

_____

Please indicate if the child has ever had any of the following.

	Yes	**No**
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

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 athlete _____ Signature of parent/guardian _____ Date _____

New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

PARENT COMPLETES

Section 2

This section is completed by your child's doctor.

If your child does not have a pediatrician, please contact the office of Dr. Kia Calhoun Grundy at 908.810.8551 or visit 2333 Morris Avenue, Suite B218 in Union.

NOTE: The preparticiaption physical examination must be conducted by a health care provider who 1) is a licensed physician, advanced practician nurse, or physician assistant; and 2) completed the Student-Athlete Cardiac Assessment Professional Development Module.

PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

DOCTOR COMPLETES BOTH SIDES

PHYSICIAN REMINDERS

1. **Consider additional questions on more sensitive issues**
   - **Do you feel stressed out or under a lot of pressure?**
   - **Do you ever feel sad, hopeless, depressed, or anxious?**
   - **Do you feel safe at your home or residence?**
   - **Have you ever tried cigarettes, chewing tobacco, snuff, or dip?**
   - **During the past 30 days, did you use chewing tobacco, snuff, or dip?**
   - **Do you drink alcohol or use any other drugs?**
   - **Have you ever taken anabolic steroids or used any other performance supplement?**
   - **Have you ever taken any supplements to help you gain or lose weight or improve your performance?**
   - **Do you wear a seat belt, use a helmet, and use condoms?**
2. **Consider reviewing questions on cardiovascular symptoms (questions 5–14).**

EXAMINATION		
Height Weight ☐ Male ☐ Female		
BP / (/) Pulse Vision R 20/ L 20/ Corrected ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason _____

Recommendations _____

_____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) (print/type)_____ Date _____

Address _____ Phone _____

Signature of physician, APN, PA _____

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Physical Evaluation CLEARANCE FORM

Name _____ Sex ☐ M ☐ F Age _____ Date of birth _____

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason _____

Recommendations _____

_____

_____

_____

_____

_____

EMERGENCY INFORMATION

Allergies _____

_____

_____

_____

_____

_____

Other information _____

_____

_____

_____

_____

HCP OFFICE STAMP

SCHOOL PHYSICIAN:

Reviewed on _____
(Date)

Approved _____ Not Approved _____

Signature:_____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athle (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) _____ Date _____

Address _____ Phone _____

Signature of physician, APN, PA _____

Completed Cardiac Assessment Professional Development Module

Date_____ Signature_____

DOCTOR COMPLETES

New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

Section 3

This section is to be completed only if the child has to take any medication during school hours or has asthma, allergies or seizures.

A doctor must sign all forms that apply.

PARENT/GUARDIAN: Doctor **MUST** complete & sign this form if student takes medication.

MEDICATION ADMINISTRATION REQUEST *for conditions other than asthma, allergies or seizures*

Medication must be provided directly to the school nurse in the original container & must not be expired. Only medication that is required during school hours will be administered.

Student's Name _____ Date of Birth _____

PARENT/GUARDIAN SIGNATURE

I authorize the school nurse to administer the following medication as prescribed by the physician to my child.

_____ _____

Parent/Guardian Signature Date

TO BE COMPLETED BY THE PHYSICIAN

Student Diagnosis _____

Medication	Purpose	Dosage	Route	Frequency

Side Effects _____

Check all that may apply: ☐ Self Administers [see Medication Policy] ☐ Nurse Administers ☐ Medicates at Home

_____ _____

Physician's Signature Date

PHYSICIAN CONTACT INFORMATION

Phone _____ Fax _____

Address _____ City & ZIP-code _____

Asthma Treatment Plan – Student

(This asthma action plan meets NJ Law N.J.S.A. 18A:40-12.8) **(Physician's Orders)**

The Pediatric/Adult Asthma Coalition of New Jersey
"Your Pathway to Asthma Control"
PACNJ approved Plan available at www.pacnj.org

Sponsored by American Lung Association in New Jersey

NJ Health New Jersey Department of Health

(Please Print)

Name	Date of Birth	Effective Date
Doctor Phone	Parent/Guardian (if applicable) Phone	Emergency Contact Phone

HEALTHY (Green Zone)

You have *all* of these:
- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work, exercise, and play

And/or Peak flow above _____

Take daily control medicine(s). Some inhalers may be more effective with a "spacer" – use if directed.

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Advair® HFA ☐ 45, ☐ 115, ☐ 230	2 puffs twice a day
☐ Aerospan™	☐ 1, ☐ 2 puffs twice a day
☐ Alvesco® ☐ 80, ☐ 160	☐ 1, ☐ 2 puffs twice a day
☐ Dulera® ☐ 100, ☐ 200	2 puffs twice a day
☐ Flovent® ☐ 44, ☐ 110, ☐ 220	2 puffs twice a day
☐ Qvar® ☐ 40, ☐ 80	☐ 1, ☐ 2 puffs twice a day
☐ Symbicort® ☐ 80, ☐ 160	☐ 1, ☐ 2 puffs twice a day
☐ Advair Diskus® ☐ 100, ☐ 250, ☐ 500	1 inhalation twice a day
☐ Asmanex® Twisthaler® ☐ 110, ☐ 220	☐ 1, ☐ 2 inhalations ☐ once or ☐ twice a day
☐ Flovent® Diskus® ☐ 50 ☐ 100 ☐ 250	1 inhalation twice a day
☐ Pulmicort Flexhaler® ☐ 90, ☐ 180	☐ 1, ☐ 2 inhalations ☐ once or ☐ twice a day
☐ Pulmicort Respules® (Budesonide) ☐ 0.25, ☐ 0.5, ☐ 1.0	1 unit nebulized ☐ once or ☐ twice a day
☐ Singulair® (Montelukast) ☐ 4, ☐ 5, ☐ 10 mg	1 tablet daily
☐ Other	
☐ None	

Remember to rinse your mouth after taking inhaled medicine.

If exercise triggers your asthma, take_____ ____ puff(s) ____minutes before exercise.

CAUTION (Yellow Zone)

You have *any* of these:
- Cough
- Mild wheeze
- Tight chest
- Coughing at night
- Other:_____

If quick-relief medicine does not help within 15-20 minutes or has been used more than 2 times and symptoms persist, call your doctor or go to the emergency room.

And/or Peak flow from_____ to_____

Continue daily control medicine(s) and ADD quick-relief medicine(s).

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	2 puffs every 4 hours as needed
☐ Xopenex®	2 puffs every 4 hours as needed
☐ Albuterol ☐ 1.25, ☐ 2.5 mg	1 unit nebulized every 4 hours as needed
☐ Duoneb®	1 unit nebulized every 4 hours as needed
☐ Xopenex® (Levalbuterol) ☐ 0.31, ☐ 0.63, ☐ 1.25 mg	1 unit nebulized every 4 hours as needed
☐ Combivent Respimat®	1 inhalation 4 times a day
☐ Increase the dose of, or add:	
☐ Other	

- **If quick-relief medicine is needed more than 2 times a week, except before exercise, then call your doctor.**

EMERGENCY (Red Zone)

Your asthma is getting worse fast:
- Quick-relief medicine did not help within 15-20 minutes
- Breathing is hard or fast
- Nose opens wide • Ribs show
- Trouble walking and talking
- Lips blue • Fingernails blue
- Other:_____

And/or Peak flow below _____

Take these medicines NOW and CALL 911.
Asthma can be a life-threatening illness. Do not wait!

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	4 puffs every 20 minutes
☐ Xopenex®	4 puffs every 20 minutes
☐ Albuterol ☐ 1.25, ☐ 2.5 mg	1 unit nebulized every 20 minutes
☐ Duoneb®	1 unit nebulized every 20 minutes
☐ Xopenex® (Levalbuterol) ☐ 0.31, ☐ 0.63, ☐ 1.25 mg	1 unit nebulized every 20 minutes
☐ Combivent Respimat®	1 inhalation 4 times a day
☐ Other	

Triggers

Check all items that trigger patient's asthma:

- ❑ Colds/flu
- ❑ Exercise
- ❑ Allergens
  - ❍ Dust Mites, dust, stuffed animals, carpet
  - ❍ Pollen - trees, grass, weeds
  - ❍ Mold
  - ❍ Pets - animal dander
  - ❍ Pests - rodents, cockroaches
- ❑ Odors (Irritants)
  - ❍ Cigarette smoke & second hand smoke
  - ❍ Perfumes, cleaning products, scented products
  - ❍ Smoke from burning wood, inside or outside
- ❑ Weather
  - ❍ Sudden temperature change
  - ❍ Extreme weather - hot and cold
  - ❍ Ozone alert days
- ❑ Foods:
  - ❍ _____
  - ❍ _____
  - ❍ _____
- ❑ Other:
  - ❍ _____
  - ❍ _____
  - ❍ _____

This asthma treatment plan is meant to assist, not replace, the clinical decision-making required to meet individual patient needs.

The Pediatric/Adult Asthma Coalition of New Jersey, sponsored by the American Lung Association in New Jersey. This publication was supported by a grant from the New Jersey Department of Health and Senior Services, with funds provided by the U.S. Centers for Disease Control and Prevention under Cooperative Agreement 5U58EH000401-5. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the New Jersey Department of Health and Senior Services or the U.S. Centers for Disease Control and Prevention. Although this document has been funded wholly or in part by the United States Environmental Protection Agency under Agreement XA96296601-2 to the American Lung Association in New Jersey, it has not gone through the Agency's publications review process and therefore, may not necessarily reflect the views of the Agency and no official endorsement should be inferred. Information in this publication is not intended to diagnose health problems or take the place of medical advice. For asthma or any medical condition, seek medical advice from your child's or your health care professional.

Permission to Self-administer Medication:

☐ This student is capable and has been instructed in the proper method of self-administering of the non-nebulized inhaled medications named above in accordance with NJ Law.

☐ This student is not approved to self-medicate.

PHYSICIAN/APN/PA SIGNATURE_____ DATE_____
Physician's Orders

PARENT/GUARDIAN SIGNATURE_____

PHYSICIAN STAMP

REVISED AUGUST 2014
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Asthma Treatment Plan – Student
Parent Instructions

The **PACNJ Asthma Treatment Plan** is designed to help everyone understand the steps necessary for the individual student to achieve the goal of controlled asthma.

1. Parents/Guardians: *Before taking this form to your Health Care Provider,* complete the top left section with:
- Child's name
- Child's date of birth
- Child's doctor's name & phone number
- An Emergency Contact person's name & phone number
- Parent/Guardian's name & phone number

2. Your Health Care Provider will complete the following areas:
- The effective date of this plan
- The medicine information for the Healthy, Caution and Emergency sections
- Your Health Care Provider will check the box next to the medication and check how much and how often to take it
- Your Health Care Provider may check **"OTHER" and:**
  - ❖ **Write in asthma medications not listed on the form**
  - ❖ **Write in additional medications that will control your asthma**
  - ❖ **Write in generic medications in place of the name brand on the form**
- Together you and your Health Care Provider will decide what asthma treatment is best for your child to follow

3. Parents/Guardians & Health Care Providers together will discuss and then complete the following areas:
- Child's peak flow range in the Healthy, Caution and Emergency sections on the left side of the form
- Child's asthma triggers on the right side of the form
- Permission to Self-administer Medication section at the bottom of the form: Discuss your child's ability to self-administer the inhaled medications, check the appropriate box, and then both you and your Health Care Provider must sign and date the form

4. Parents/Guardians: *After completing the form with your Health Care Provider:*
- Make copies of the Asthma Treatment Plan and give the signed original to your child's school nurse or child care provider
- Keep a copy easily available at home to help manage your child's asthma
- Give copies of the Asthma Treatment Plan to everyone who provides care for your child, for example: babysitters, before/after school program staff, coaches, scout leaders

PARENT AUTHORIZATION

I hereby give permission for my child to receive medication at school as prescribed in the Asthma Treatment Plan. Medication must be provided in its original prescription container properly labeled by a pharmacist or physician. I also give permission for the release and exchange of information between the school nurse and my child's health care provider concerning my child's health and medications. In addition, I understand that this information will be shared with school staff on a need to know basis.

Parent/Guardian Signature _____ Phone _____ Date _____

FILL OUT THE SECTION BELOW ONLY IF YOUR HEALTH CARE PROVIDER CHECKED PERMISSION FOR YOUR CHILD TO SELF-ADMINISTER ASTHMA MEDICATION ON THE FRONT OF THIS FORM.

RECOMMENDATIONS ARE EFFECTIVE FOR ONE (1) SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY

☐ I do request that my child be **ALLOWED** to carry the following medication _____ for self-administration in school pursuant to N.J.A.C:.6A:16-2.3. I give permission for my child to self-administer medication, as prescribed in this Asthma Treatment Plan for the current school year as I consider him/her to be responsible and capable of transporting, storing and self-administration of the medication. Medication must be kept in its original prescription container. I understand that the school district, agents and its employees shall incur no liability as a result of any condition or injury arising from the self-administration by the student of the medication prescribed on this form. I indemnify and hold harmless the School District, its agents and employees against any claims arising out of self-administration or lack of administration of this medication by the student.

☐ I **DO NOT** request that my child self-administer his/her asthma medication.

Parent/Guardian Signature _____ Phone _____ Date _____

The Pediatric/Adult Asthma Coalition of New Jersey
"Your Pathway to Asthma Control"
PACNJ approved Plan available at www.pacnj.org

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IN NEW JERSEY

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: [ ] **Yes (higher risk for a severe reaction)** [ ] **No**

PLACE PICTURE HERE

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following foods: _____

THEREFORE:

[ ] If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

[ ] If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Short of breath, wheezing, repetitive cough

HEART
Pale, blue, faint, weak pulse, dizzy

THROAT
Tight, hoarse, trouble breathing/ swallowing

MOUTH
Significant swelling of the tongue and/or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell them the child is having anaphylaxis and may need epinephrine when they arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport them to ER even if symptoms resolve. Person should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/ discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand: _____

Epinephrine Dose: [ ] 0.15 mg IM [ ] 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

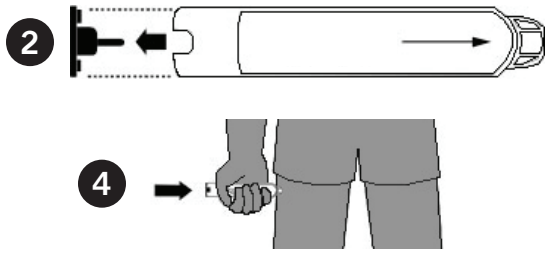
PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

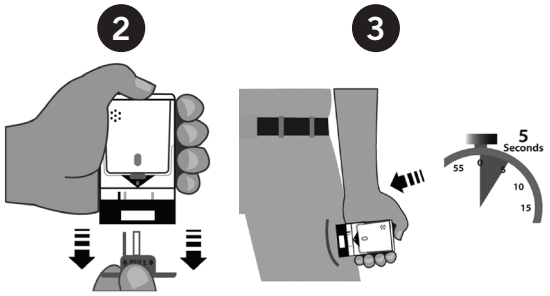
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



ADRENACLICK®/ADRENACLICK® GENERIC DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled “1” and “2”.
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.)**:**

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can get worse quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 5/2014

EPILEPSY FOUNDATION®
Not another moment lost to seizures

Seizure Action Plan

Effective Date

This student is being treated for a seizure disorder. The information below should assist you if a seizure occurs during school hours.

Student's Name | Date of Birth

Parent/Guardian | Phone | Cell

Other Emergency Contact | Phone | Cell

Treating Physician | Phone

Significant Medical History

Seizure Information

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs:

Student's response after a seizure:

Basic First Aid: Care & Comfort

Please describe basic first aid procedures:

Does student need to leave the classroom after a seizure? ❒ Yes ❒ No

If YES, describe process for returning student to classroom:

Emergency Response

A "seizure emergency" for this student is defined as:

Seizure Emergency Protocol
(Check all that apply and clarify below)

- ❒ Contact school nurse at _____
- ❒ Call 911 for transport to _____
- ❒ Notify parent or emergency contact
- ❒ Administer emergency medications as indicated below
- ❒ Notify doctor
- ❒ Other _____

Basic Seizure First Aid

- Stay calm & track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Record seizure in log

For tonic-clonic seizure:

- Protect head
- Keep airway open/watch breathing
- Turn child on side

A seizure is generally considered an emergency when:

- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has a first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

Treatment Protocol During School Hours (include daily and emergency medications)

Emerg. Med. ✓	Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Does student have a **Vagus Nerve Stimulator?** ❒ Yes ❒ No If YES, describe magnet use:

Special Considerations and Precautions (regarding school activities, sports, trips, etc.)

Describe any special considerations or precautions:

Physician Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____

DPC772

New Jersey Department of Health
MINIMUM IMMUNIZATION REQUIREMENTS FOR SCHOOL ATTENDANCE IN NEW JERSEY
N.J.A.C. 8:57-4: IMMUNIZATION OF PUPILS IN SCHOOL

Disease(s)	Meets Immunization Requirements	Comments
DTaP//DTP	**Age 1-6 years:** 4 doses, with one dose given on or after the 4th birthday, OR any 5 doses. **Age 7-9 years:** 3 doses of Td or any previously administered combination of DTP, DTaP, and DT to equal 3 doses	Any child entering pre-school, and/or pre-Kindergarten needs a minimum of 4 doses. A booster dose is needed on or after the fourth birthday, to be in compliance with Kindergarten attendance requirements. Pupils after the seventh birthday should receive adult type Td. Please note: there is no acceptable titer test for pertussis.
Tdap	**Grade 6** (or comparable age level for special education programs): 1 dose	For pupils entering Grade 6 on or after 9-1-08 and born on or after 1-1-97. A child is not required to have a Tdap dose until FIVE years after the last DTP/DTaP or Td dose.
Polio	**Age 1-6 years**: 3 doses, with one dose given on or after the 4th birthday, OR any 4 doses. **Age 7 or Older:** Any 3 doses	Any child entering pre-school, and/or pre-Kindergarten needs a minimum of 3 doses. A booster dose is needed on or after the fourth birthday to be in compliance with Kindergarten attendance requirements. Either Inactivated polio vaccine (IPV) or oral polio vaccine (OPV) separately or in combination is acceptable. Polio vaccine is not required of pupils 18 years or older.*
Measles	If born before 1-1-90, 1 dose of a live measles-containing vaccine on or after the first birthday. If born on or after 1-1-90, 2 doses of a live measles-containing vaccine on or after the first birthday.	Any child over 15 months of age entering child care, pre-school, or pre-Kindergarten needs a minimum of 1 dose of measles vaccine. Any child entering Kindergarten needs 2 doses. Intervals between first and second measles-containing vaccine doses cannot be less than 1 month. Laboratory evidence of immunity is acceptable.**
Rubella and Mumps	1 dose of live mumps-containing vaccine on or after the first birthday. 1 dose of live rubella-containing vaccine on or after the first birthday	Any child over 15 months of age entering child care, pre-school, or pre-Kindergarten needs 1 dose of rubella and mumps vaccine. Any child entering Kindergarten needs 1 dose each. Laboratory evidence of immunity is acceptable. **
Varicella	1 dose on or after the first birthday	All children 19 months of age and older enrolled into a child care/pre-school center after 9-1-04 or children born on or after 1-1-98 entering the school for the first time in Kindergarten or Grade 1 need 1 dose of varicella vaccine. Laboratory evidence of immunity, physician's statement or a parental statement of previous varicella disease is acceptable.
Haemophilus influenzae B (Hib)	**Age 2-11 Months**: 2 doses **Age 12-59 Months**: 1 dose	Mandated only for children enrolled in child care, pre-school, or pre-Kindergarten: Minimum of 2 doses of Hib-containing vaccine is needed if between the ages of 2-11 months. Minimum of 1 dose of Hib-containing vaccine is needed after the first birthday. ***
Hepatitis B	**K-Grade 12**: 3 doses or **Age 11-15 years**: 2 doses	If a child is between 11-15 years of age and has not received 3 prior doses of Hepatitis B then the child is eligible to receive 2-dose Hepatitis B Adolescent formulation.
Pneumococcal	**Age 2-11 months**: 2 doses **Age 12-59 months**: 1 dose	Mandated only for children enrolled in child care, pre-school, or pre-Kindergarten: Minimum of 2 doses of pneumococcal conjugate vaccine is needed if between the ages of 2-11 months. Minimum of 1 dose of pneumococcal conjugate vaccine is needed after the first birthday. ***
Meningococcal	Entering Grade 6 (or comparable age level for Special Ed programs): 1 dose	For pupils entering Grade 6 on or after 9-1-08 and born on or after 1-1-97. *** This applies to students when they turn 11 years of age and attending Grade 6.
Influenza	**Ages 6-59 Months**: 1 dose annually	For children enrolled in child care, pre-school, or pre-Kindergarten on or after 9-1-08. 1 dose to be given between September 1 and December 31 of each year. Students entering school after December 31 up until March 31 must receive 1 dose since it is still flu season during this time period.

*** Footnote**: The requirement to receive a school entry booster dose of DTP or DTaP after the child's 4th birthday shall not apply to children while in child care centers, preschool or pre-kindergarten classes or programs.

The requirement to receive a school entry dose of OPV or IPV after the child's 4th birthday shall not apply to children while in child care centers, preschool or pre-kindergarten classes or programs.

**** Footnote**: Antibody Titer Law (Holly's Law)—This law specifies that a titer test demonstrating immunity be accepted in lieu of receiving the second dose of measles-containing vaccine. The tests used to document immunity must be approved by the U.S. Food and Drug Administration (FDA) for this purpose and performed by a laboratory that is CLIA certified.

***** Footnote**: No acceptable immunity tests currently exist for Haemophilus Influenzae type B, Pneumococcal, and Meningococcal.

Please Note The Following:

The specific vaccines and the number of doses required are intended to establish the minimum vaccine requirements for child-care center, preschool, or school entry and attendance in New Jersey. These intervals are not based on the allotted time to receive vaccinations. The intervals indicate the vaccine doses needed at earliest age at school entry. Additional vaccines, vaccine doses, and proper spacing between vaccine doses are recommended by the Department in accordance with the guidelines of the American Academy of Pediatrics (AAP) and Advisory Committee on Immunization Practices (ACIP), as periodically revised, for optimal protection and additional vaccines or vaccine doses may be administered, although they are not required for school attendance unless otherwise specified.

Serologic evidence of immunity (titer testing) is only accepted as proof of immunity when no vaccination documentation can be provided or prior history is questionable. It cannot be used in lieu of receiving the full recommended vaccinations.

Provisional Admission:
Provisional admission allows a child to enter/attend school after having received a minimum of one dose of each of the required vaccines. Pupils must be actively in the process of completing the series. Pupils <5 years of age, must receive the required vaccines within 17 months in accordance with the ACIP recommended minimum vaccination interval schedule. Pupils 5 years of age and older, must receive the required vaccines within 12 months in accordance with the ACIP recommended minimum vaccination interval schedule.

Grace Periods:

- 4-day grace period: All vaccine doses administered less than or equal to four days before either the specified minimum age or dose spacing interval shall be counted as valid and shall not require revaccination in order to enter or remain in a school, pre-school, or child care facility.
- 30-day grace period: Those children transferring into a New Jersey school, pre-school, or child care center from out of state/out of country may be allowed a 30-day grace period in order to obtain past immunization documentation before provisional status shall begin.