SCHOOL	GRADE	STUDENT NAME

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

KIPP NJ
Physical Forms

The forms in this packet must be completed by your child's doctor & the parent/guardian.

This physical packet is due before the 1st day of summer school, or your child will not be able to attend school.

Dear Parent/Guardian,

We at KIPP NJ pride ourselves on delivering the best health care possible to each and every one of our scholars. It is our mission and joy in life to make sure that when your child walks into his/her school building, they are not only recieving a quality education but they are safe, happy, and healthy as well!
In order to achieve this goal of safe, happy, healthy scholars we need your help!

All new incoming scholars are required to submit the KIPP NJ Physical form (which must have been completed less than 12 months ago) as well as an up to date immunization record.

If you are having difficulty completing the above stated requirements please note the following resources for your convenience:

Immunization Resource(s):

Newark Dept. of Child & Family Wellness
110 William St. Newark, NJ 07102
(FREE Immunizations available to all Newark Residents)
973.733.7580

Camden County Immunization Program
600 Market St. Camden, NJ 08102
(FREE Immunizations for Camden residents with no insurance)
856.225.5128

Physical Form Resource:
If you require assistance in (1) finding a pediatrician or (2) paying for a physical examination for your child please contact your school nurse, as we may be able to help.

If you have any questions or concerns about any of the documents that we require, please feel free to reach out to us. We would be more than happy to assist you in finding any resources or health services for your child!

Love,
The School Nurses

Kipp: Cooper Norcross Academy,	Nurse Villa-Gonzalez,	856.966.9600 EXT 2
Life Academy,	Nurse Byrne,	973.705.3206 EXT 4
Newark Collegiate Academy,	Nurse Reynolds,	973.624.1622 EXT 5
RISE Academy,	Nurse Randall,	973.242.7473 EXT 4
Seek Academy,	Nurse Leal,	973.481.7583 EXT 3
SPARK Academy,	Nurse Chavez-Ortiz,	973.481.0327 EXT 6
TEAM Academy,	Nurse Gayles,	973.705.8326 EXT 5
Thrive/Bold Academy,		973.273.7272 EXT 6

KIPP NJ STUDENT HEALTH INFORMATION & RELEASE

Section 1: GENERAL INFORMATION

Student's Name _____ Date of Birth _____

Parent's Name _____ Parent's Phone Number _____

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

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.

_____

_____

Section 3: OVER-THE-COUNTER MEDICATION & EMERGENCY TREATMENT

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

I agree that KIPP NJ and its employees are not to be held liable for giving medicine in accordance with this Authorization. I agree to hold harmless and indemnify KIPP NJ 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. intend to be legally bound by this Authorization.

In the event a parent/guardian cannot be reached, I hereby give permission to KIPP NJ 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 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

_____ _____

Parent/Guardian Signature Date

KIPP NJ 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.

Parent/guardian Initial: _____

OVER THE COUNTER MEDICATIONS

The only over the counter medications that will be provided by the school and administered in school will be the ones outlined in the *Standing Medication Orders* as indicated and for the purpose noted by the KIPP NJ School Physician. 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 unless cleared by a doctor to self administer. In this case the student 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. Please note this allowance is not applicable for elementary aged students.

Parent/guardian Initial: _____

FIELD TRIPS

Please be advised that the school nurse will not be accompanying the staff and students on field trips. Parents or guardians are responsible to ensure that their child receives their respective medications during the trip and are properly educated on the use of any prescribed medications or treatments that may be needed during this trip. Please note, teachers are not able to administer medications during field trips.

Parent/guardian Initial: _____

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.

Parent/guardian Initial: _____

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 including but not limited to 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.

Parent/guardian Initial: _____

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 so that corrective measures can be taken immediately.

_____ _____

Parent/Guardian Signature Date

PHYSICAL EVALUATION
History Form

Parent/Guardian please complete this page

(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 parent/guardian _____ Date _____

PHYSICAL EVALUATION

Physical Examination Form

Name _____ Date of birth _____

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.

Limitations:

_____

_____

Recommendations:

_____

_____

Signature of physician, APN, PA _____

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

Address _____ Phone _____

HCP OFFICE STAMP

PHYSICAL EVALUATION

Cardiac Clearance

Doctor/Practitioner please complete this page
Please Note: Cardiac Clearance only required for Middle & High School students

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 athlete (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_____

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
Immunization Clearance

Doctor/Practitioner please complete this page
Note: You may attach an up to date immunization record in place of filling out this page

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

VACCINE TYPE	1st Dose Mo/Day/Yr	2nd Dose Mo/Day/Yr	3rd Dose Mo/Day/Yr	4th Dose Mo/Day/Yr	5th Dose Mo/Day/Yr	LEAD SCREENING	
						Test Date	Result
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination *(If Td or DT, indicate in corner box)*							
Tdap							
POLIO – INACTIVATED POLIO VACCINE (IPV) *If oral vaccine, indicate (OPV) in corner box*							
MEASLES, MUMPS, RUBELLA (MMR)					**Document below single antigen vaccine receipt, serology titers, or varicella disease history**		
HAEMOPHILUS B (HIB)**							
HEPATITIS B					Hepatitis B	Date:	Titer:
VARICELLA					Varicella	Date:	Titer:
PNEUMOCOCCAL CONJUGATE **					Measles	Date:	Titer:
MENINGOCOCCAL					Mumps	Date:	Titer:
HEPATITIS A ***					Rubella	Date:	Titer:
HPV (HUMAN PAPILLOMAVIRUS) ***							
OTHER							

☐ Provisional admission attached–Date Granted:_____ ☐ Medical exemption attached ☐ Religious exemption attached

Please Note that KIPP NJ requires that all incoming 6th grade students recieve the first dose of the Meningococcol & Tdap vaccines prior to the start of 6th grade or no later than the 11th birthday of the child.

Has this child recieved the first dose of the MCV4 Meningococcol Vaccine? ☐ Yes ☐ No

If Meningococcol vaccine was not given due to age please specify when patient is scheduled to return for vaccination:

Appointment Date: _____

Has this child recieved the first dose of the Tdap Vaccine? ☐ Yes ☐ No

If Tdap vaccine was not given due to age please specify when patient is scheduled to return for vaccination:

Appointment Date: _____

Has this child recieved a PPD/Mantoux during this doctors visit? ☐ Yes ☐ No

Date Placed: _____ Location: _____

Date Read: _____ Results (mm):

Read by: _____

Practitioner Signature: _____

Health Office Use only:

Based on his/her current immunization status, is this child cleared to start school? ☐ Yes ☐ No

If not, which immunization(s) or document(s) are missing? : _____

_____

School Nurse Signature: _____ Date: _____

Please have your child's doctor complete the following attached forms if your child has:

1. **Asthma**
2. **Food Allergies**
3. **Requires any kind of medication during school hours**

A doctor must sign all forms that apply.

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.

REVISED AUGUST 2014

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

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): _____

_____

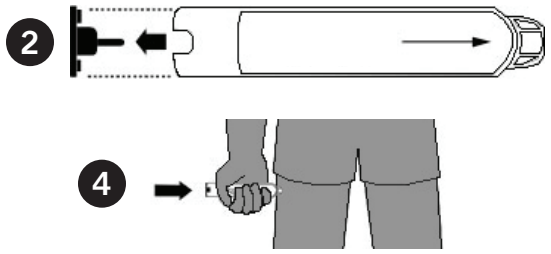
PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

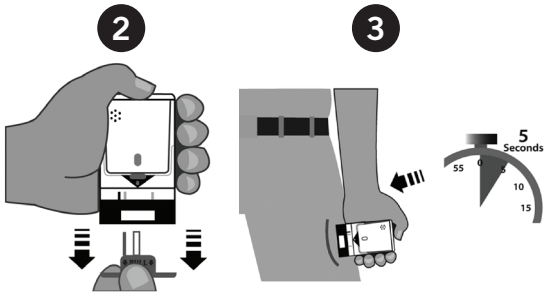
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

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

KIPP New Jersey

Medication Administration Form

KIPP NEW JERSEY | 60 PARK PLACE, #802, NEWARK, NJ 07102 | P 973.622.0905 | F 973.556.1441 | www.kippnj.org

STUDENT	Parent
School Year	Legal Guardian
School	Home Phone
Teacher	Work Phone
Grade	Cell Phone

TO BE COMPLETED BY THE PRESCRIBING HEALTHCARE PROVIDER. **USE A SEPARATE FORM FOR EACH MEDICATION.**

Name of Medication	___mg per tablet ___mg per tsp/5ml	take_____tablet(s) take_____tsp	Total mg per dose	Time to take every day, or as needed

Reason for Medication: ADHD Headache/Migraine Pain Other _____

Side Effects / Precautions: ----------

Start Date: / / Stop Date: / /

Note: The School Nurse will keep and give this medication for this student unless otherwise noted below.

This student is capable of keeping/taking this medication on his/her own: Yes ☐ No ☐

Note: All controlled, stimulant and/or narcotic medication must be given and supervised by school personnel for all students at all grade levels.

Healthcare Provider Signature ---------- Date: ----------

Healthcare Provider (PRINT) ---------- Phone: ----------

TO BE COMPLETED BY PARENT/ LEGAL GUARDIAN

Please Note: All Medication must be in a properly labeled pharmacy or store container.

I hereby give my permission for my child (named above) to receive this (stated) medication at school. I assume full responsibility and will inform school staff of arty medication changes or health status.
I hereby release KIPP NJ, their agents, and employees from any and all liability that may occur as a result of any medication administration.
I will provide a new medication form each school year and each time the dose/medication changes.
I agree to furnish medication in an original, properly labeled pharmacy or store container.
I will pick-up unused/discontinued medication as needed during (or by end of) the school year.

*Parent/Legal Guardian Signature*_____ *Date*_____

Health Office Use Only:

Reviewed by School Nurse: _____

School Nurse Date

File original in Individual Health Record *Copy to staff administering medication*

KIPP: Work hard. Be nice.