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

This physical packet is due within 30 days:
- Returning students: 30 days from the first day of school
- New students: 30 days from registration

When submitting this form, we STRONGLY recommend that you submit it directly to the nurse’s office to ensure it does not get misplaced!
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 receiving 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:**

Newark Dept. of Child & Family Wellness  
110 William Street, Newark, NJ 07102  
973-733-7580

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 SPARK Academy         973-481-0327   EXT  6  
KIPP THRIVE Academy         973-273-7272   EXT  6  
KIPP Seek Academy           973-481-7583   EXT  2  
KIPP Life Academy           973-705-3206   EXT  4  
KIPP Upper Roseville Academy 973-7571480    
KIPP TEAM Academy           973-705-8326   EXT  1  
KIPP Rise Academy           973-242-7473   EXT  4  
KIPP BOLD Academy           973-273-7272   EXT  6  
KIPP Newark Community Prep  973-757-1502    
KIPP Newark Collegiate Academy 973-624-1622   EXT  4  
KIPP Newark Lab High School  973-757-1501    
# KIPP NJ STUDENT HEALTH INFORMATION & RELEASE

## Section 1: GENERAL INFORMATION

<table>
<thead>
<tr>
<th>Student’s Name</th>
<th>Date of Birth</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Parent’s Name</th>
<th>Parent’s Phone Number</th>
</tr>
</thead>
</table>

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 medications 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. I 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

<table>
<thead>
<tr>
<th>Parent/Guardian Signature</th>
<th>Date</th>
</tr>
</thead>
</table>
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 __________
Preparticipation Physical Evaluation

HISTORY EVALUATION

(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 ___________________________ Date of birth ___________________________

Name ___________________________ ___________________________ ___________________________

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.

☐ Yes ☐ No

Do you have any allergies? 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.

1. Has a doctor ever denied or restricted your participation in sports for any reason?

☐ Yes ☐ No

2. Have you ever had surgery?

☐ Yes ☐ No

3. Did you have a heart murmur?

☐ Yes ☐ No

4. Do you have a history of seizures?

☐ Yes ☐ No

5. Have you ever worn a brace?

☐ Yes ☐ No

6. Have you been told that you have a heart murmur?

☐ Yes ☐ No

7. Have you ever worn a brace?

☐ Yes ☐ No

8. Have you ever been told that you have a heart murmur?

☐ Yes ☐ No

9. Have you ever worn a brace?

☐ Yes ☐ No

10. Have you ever been told that you have a heart murmur?

☐ Yes ☐ No

11. Have you ever worn a brace?

☐ Yes ☐ No

12. Have you ever been told that you have a heart murmur?

☐ Yes ☐ No

13. Have you ever worn a brace?

☐ Yes ☐ No

14. Have you ever been told that you have a heart murmur?

☐ Yes ☐ No

15. Have you ever worn a brace?

☐ Yes ☐ No

16. Have you ever been told that you have a heart murmur?

☐ Yes ☐ No

17. Have you ever worn a brace?

☐ Yes ☐ No

18. Have you ever been told that you have a heart murmur?

☐ Yes ☐ No

19. Have you ever worn a brace?

☐ Yes ☐ No

20. Have you ever been told that you have a heart murmur?

☐ Yes ☐ No

21. Have you ever worn a brace?

☐ Yes ☐ No

22. Have you ever been told that you have a heart murmur?

☐ Yes ☐ No

23. Have you ever worn a brace?

☐ Yes ☐ No

24. Have you ever been told that you have a heart murmur?

☐ Yes ☐ No

25. Have you ever worn a brace?

☐ Yes ☐ No

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 ___________________________

**Preparticipation Physical Evaluation**

**The Athlete with Special Needs: Supplemental History Form**

Date of Exam _______________________________  Date of birth: _______________________________

Name ____________________________________________________  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 you are interested in playing: ______

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.</td>
<td>Do you regularly use a brace, assistive device, or prosthetic?</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Do you use any special brace or assistive device for sports?</td>
<td></td>
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<tr>
<td>8.</td>
<td>Do you have any rashes, pressure sores, or any other skin problems?</td>
<td></td>
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<tr>
<td>9.</td>
<td>Do you have a hearing loss? Do you use a hearing aid?</td>
<td></td>
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<tr>
<td>10.</td>
<td>Do you have a visual impairment?</td>
<td></td>
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<tr>
<td>11.</td>
<td>Do you use any special devices for bowel or bladder function?</td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>Do you have burning or discomfort when urinating?</td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>Have you had autonomic dysreflexia?</td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?</td>
<td></td>
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<tr>
<td>15.</td>
<td>Do you have muscle spasticity?</td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>Do you have frequent seizures that cannot be controlled by medication?</td>
<td></td>
</tr>
</tbody>
</table>

Explain “yes” answers here: ______________________________

Please indicate if you have ever had any of the following.

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atlantoaxial instability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X-ray evaluation for atlantoaxial instability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Didlocated joints (more than one)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Easy bleeding</td>
<td></td>
<td></td>
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<tr>
<td>Enlarged spleen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis</td>
<td></td>
<td></td>
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<tr>
<td>Osteopenia or osteoporosis</td>
<td></td>
<td></td>
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<tr>
<td>Difficult controlling bowel</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficult controlling bladder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Numbness or tingling in arms or hands</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Numbness or tingling in legs or feet</td>
<td></td>
<td></td>
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<tr>
<td>Weakness in arms or hands</td>
<td></td>
<td></td>
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<tr>
<td>Weakness in legs or feet</td>
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<td></td>
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<tr>
<td>Recent change in coordination</td>
<td></td>
<td></td>
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<tr>
<td>Recent change in ability to walk</td>
<td></td>
<td></td>
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<tr>
<td>Spina bifida</td>
<td></td>
<td></td>
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<tr>
<td>Latex allergy</td>
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</tr>
</tbody>
</table>

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
# Preparticipation 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?

2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

<table>
<thead>
<tr>
<th>EXAMINATION</th>
<th>WEIGHT</th>
<th>HEIGHT</th>
<th>BP</th>
<th>PULSE</th>
<th>MEDICAL</th>
<th>NORMAL</th>
<th>ABNORMAL FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Appearance</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>• Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span &gt; height, hyperlaxity, myopia, MVP, aortic insufficiency)</td>
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<tr>
<td><strong>Eyes/ears/nose/throat</strong></td>
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<tr>
<td>• Pupils equal</td>
<td></td>
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<tr>
<td>• Hearing</td>
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<tr>
<td><strong>Lymph nodes</strong></td>
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<tr>
<td><strong>Heart</strong></td>
<td></td>
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<tr>
<td>• Murmurs (auscultation, standing, supine, Valsalva)</td>
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<tr>
<td>• Location of point of maximal impulse (PMI)</td>
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<td><strong>Pulses</strong></td>
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<tr>
<td>• Simultaneous femoral and radial pulses</td>
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<tr>
<td><strong>Lungs</strong></td>
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<tr>
<td><strong>Abdomen</strong></td>
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<tr>
<td><strong>Genitourinary (males only)</strong></td>
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<td><strong>Skin</strong></td>
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<td>• HSV, lesions suggestive of MRSA, lineae corporis</td>
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<td><strong>Neurologic</strong></td>
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<tr>
<td><strong>MUSCULOSKELETAL</strong></td>
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<td><strong>Neck</strong></td>
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<td><strong>Back</strong></td>
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<tr>
<td><strong>Shoulder/arm</strong></td>
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<tr>
<td><strong>Elbow/forearm</strong></td>
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<tr>
<td><strong>Wrist/hand/fingers</strong></td>
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<tr>
<td><strong>Hip/thigh</strong></td>
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<tr>
<td><strong>Knee</strong></td>
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<tr>
<td><strong>Leg/ankle</strong></td>
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<td><strong>Foot/toes</strong></td>
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<tr>
<td><strong>Functional</strong></td>
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<tr>
<td>• Duck-walk, single leg hop</td>
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</tbody>
</table>

- Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
- Consider GU exam if in private setting. Having third party present is recommended.
- 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 of exam** ____________________________

Address ____________________________  **Phone** ____________________________

Signature of physician, APN, PA ____________________________

COURT CLEARANCE

Preparticipation Physical Evaluation

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 arising 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 __________________________

**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_________

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

■ Provisional admission attached—Date Granted:_________________________ ■ Medical exemption attached ■ Religious exemption attached

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

Has this child received the first dose of the MCV4 Meningococcal Vaccine? □ Yes □ No

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

Appointment Date: ____________________________

Has this child received 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 received 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. Seizure Disorder
4. Requires any kind of medication during school hours

A doctor must sign all forms that apply.
Asthma Treatment Plan – Student
(This action plan meets NJ Law N.J.S.A. 18A:40-12.8) (Physician’s Orders)

(Please Print)

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Birth</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Doctor</th>
<th>Parent/Guardian (if applicable)</th>
<th>Emergency Contact</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Phone</th>
<th>Phone</th>
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</tr>
</tbody>
</table>

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

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

Remember to rinse your mouth after taking inhaled medicine. 

If exercise triggers your asthma, take medication _______ puffs (s) _______ minutes before exercise.

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

<table>
<thead>
<tr>
<th>MEDICINE</th>
<th>HOW MUCH to take and HOW OFTEN to take</th>
</tr>
</thead>
<tbody>
<tr>
<td>D Albuterol MDI (Pro-air® or Proventil® or Ventolin®)</td>
<td>2 puffs every 4 hours as needed</td>
</tr>
<tr>
<td>D Xopenex®</td>
<td>2 puffs every 4 hours as needed</td>
</tr>
<tr>
<td>D Albuterol D 1.25, D 2.5 mg</td>
<td>1 unit nebulized every 4 hours as needed</td>
</tr>
<tr>
<td>D Duoneb®</td>
<td>1 unit nebulized every 4 hours as needed</td>
</tr>
<tr>
<td>D Xopenex® (Levalbuterol)</td>
<td>1 inhalation 4 times a day</td>
</tr>
<tr>
<td>D Combivent Respihaler®</td>
<td>1 inhalation 4 times a day</td>
</tr>
<tr>
<td>D Increase the dose of, or add:</td>
<td></td>
</tr>
<tr>
<td>D Other</td>
<td></td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>MEDICINE</th>
<th>HOW MUCH to take and HOW OFTEN to take</th>
</tr>
</thead>
<tbody>
<tr>
<td>D Albuterol MDI (Pro-air® or Proventil® or Ventolin®</td>
<td>4 puffs every 20 minutes</td>
</tr>
<tr>
<td>D Xopenex®</td>
<td>4 puffs every 20 minutes</td>
</tr>
<tr>
<td>D Albuterol D 1.25, D 2.5 mg</td>
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<td>1 inhalation 4 times a day</td>
</tr>
<tr>
<td>D Other</td>
<td></td>
</tr>
</tbody>
</table>

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 (musty)
  • Cigarette smoke & second hand smoke
  • Perfumes, cleaning products, scented products
  • Smoke from burning wood, inside or outside
• Weather
  • Sudden change in temperature
  • 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.

Permission to Self-administer Medication:
D This student is capable and has been instructed in the proper method of self-administering of the non-nebulized inhalated medicines named above in accordance with NJ Law.
D This student is not approved to self-medicate.

PHYSICIAN/APN/P.A SIGNATURE ___________________________ DATE ____________
PARENT/GUARDIAN SIGNATURE ___________________________
PHYSICIAN STAMP ___________________________

REVISED AUGUST 2014
Permission to reproduce blank form - www.pacnj.org
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

D I do request that my child be ALLOWED to carry the following medication and use it 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.

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

Parent/Guardian Signature: __________________________
Phone: __________________________ Date: ____________

Disclaimer: The use of the website PACNJ Asthma Treatment Plan and its content is at your own risk. The content is provided on an “as is” basis. The American Lung Association of the Mid-Atlantic (ALAMA), the Pediatric/Asthma Coalition of New Jersey and its affiliates disclaim all warranties, express or implied, statutory or otherwise, including but not limited to the implied warranties of merchantability, non-infringement of third parties; and fitness for a particular purpose. ALAMA makes no representations or warranties about the accuracy, reliability, completeness, currency or timeliness of the content. ALAMA makes no warranty, representation or guarantee, that the information will be uninterrupted, timely, secure, or error-free. ALAMA is liable for any damages (including, without limitation, incidental and consequential damages, personal injury, property loss, or data loss) resulting from the use of or inability to use the content of this Asthma Treatment Plan whether based in contract, tort, or any other legal theory, and whether or not ALAMA is advised of the possibility of such damages. ALAMA and its affiliates are not liable for any action, whatsoever, caused by your use or misuse of the Asthma Treatment Plan, nor of this website.

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Sponsored by American Lung Association in New Jersey
Name: ___________________________ D.O.B.: _______________________

Allergy to: ______________________

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

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, 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.

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.

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): ______________________
**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**

<table>
<thead>
<tr>
<th>ROLE</th>
<th>NAME/RELATIONSHIP</th>
<th>PHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>RESCUE SQUAD:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DOCTOR:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PARENT/GUARDIAN:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**OTHER EMERGENCY CONTACTS**

<table>
<thead>
<tr>
<th>ROLE</th>
<th>NAME/RELATIONSHIP</th>
<th>PHONE</th>
</tr>
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</tbody>
</table>
CONTACT INFORMATION:

Student's Name: ___________________________ School Year: ___________________________
School: ___________________________ Grade: ___________________________ Classroom: ___________________________
Parent/Guardian Name: ___________________________ Tel. (H): ___________________________ (W): ___________________________ (C): ___________________________
Other Emergency Contact: ___________________________ Tel. (H): ___________________________ (W): ___________________________ (C): ___________________________
Child's Neurologist: ___________________________ Tel: ___________________________ Location: ___________________________
Child's Primary Care Dr.: ___________________________ Tel: ___________________________ Location: ___________________________
Significant medical history or conditions:

SEIZURE INFORMATION:

<table>
<thead>
<tr>
<th>Seizure Type</th>
<th>Length</th>
<th>Frequency</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Seizure triggers or warning signs: ___________________________
Response after a seizure: ___________________________

TREATMENT PROTOCOL: (include daily and emergency medications)

<table>
<thead>
<tr>
<th>Medication</th>
<th>Emergency Med?</th>
<th>Dosage &amp; Time of Day Given</th>
<th>Route of Administration</th>
<th>Common Side Effects &amp; Special Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□</td>
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<tr>
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</tr>
</tbody>
</table>

Does child have a Vagus Nerve Stimulator (VNS)? YES NO
If YES, describe magnet use ___________________________

BASIC FIRST AID, CARE & COMFORT:

Please describe basic first aid procedures: ___________________________

Does person need to leave the room/area after a seizure? YES NO
If YES, describe process for returning: ___________________________

Basic seizure first aid:
- Stay calm & track time
- Keep person safe
- Do not restrain
- Do not put anything in mouth
- Stay with person until fully conscious
- Record seizure in log
For tonic-clonic (grand mal) seizure:
- Protect head
- Keep airway open/watch breathing
- Turn person on side
EMERGENCY RESPONSE:
A “seizure emergency” for this person is defined as: ________________________________

Seizure Emergency Protocol: (Check all that apply and clarify below)
☐ Call 911 for transport to ________________________________
☐ Notify parent or emergency contact
☐ Notify doctor
☐ Administer emergency medications as indicated below
☐ Other ________________________________

SEIZURE INFORMATION:

1. When was your child diagnosed with epilepsy? ________________________________

2. How often does your child have a seizure? ________________________________

3. Has there been any recent change in your child’s seizure patterns?  YES  NO
   If YES, please explain: ________________________________

4. How do other illnesses affect your child’s seizure control? ________________________________

5. What should be done when your child misses a dose? ________________________________
   (Refer to physician care plan)

SPECIAL CONSIDERATIONS & PRECAUTIONS:
Check any special considerations related to your child’s epilepsy while at school. (Check appropriate boxes and describe the impact of your child’s seizures or treatment regimen)
☐ General health:
☐ Physical education (gym)/sports:
☐ Other: ________________________________

GENERAL COMMUNICATION ISSUES:
What is the best way for us to communicate about your child’s seizure(s)? ________________________________

Does school personnel have permission to contact your child’s physician?  YES  NO

Can this information be shared with classroom teacher(s) and other appropriate school personnel?  YES  NO

Parent Signature: ________________________________ Date: __________ Dates Updated __________, __________

Physician Signature: ________________________________ Date: __________

Once this Seizure Action Plan has been filled out, take a copy for the school nurse to keep.
Medication Administration Form

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

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Mg/mcg/ml/tsp</th>
<th>Take___tablet(s)</th>
<th>Take___tsp</th>
<th>Total mg per dose</th>
<th>Time to take daily or as needed</th>
</tr>
</thead>
</table>

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 the nurse for all students at all grade levels.

Healthcare Provider Signature __________________________________________  Date ______________________

Healthcare Provider name (Print) __________________________________________ Phone ______________________

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN

Please Note: All medication must be in a properly labeled pharmacy 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 any 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 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 __________________________________________  Date ______________________