KIPP COOPER NORCROSS

Health Packet

- **New Students:** This health packet must be completed as part of your enrollment.
- **Returning Students:** Must complete the parent section as outlined below. In addition, it is recommended that all students get an updated physical yearly.
- Please refer to the following table for completion
- **Sports:** ALL students participating in sports must have an up-to-date sports physical
- **11-year-olds:** All students who are 11 years of age must receive their Tdap and Meningococcal Vaccines
- **Asthma, Allergy, Seizure, Diabetes etc.:** All students with a Chronic health condition must submit an up-to-date Action Plan and medications must be provided in the original pharmacy container with the pharmacy label attached.

Parents *Must complete:*	**Pediatrician** *Must complete:*
➢ Page 2 – Section 1 ➢ Page 2 – Section 2 (if indicated)	➢ Physical Examination Form
➢ Page 3 – Initial all sections	➢ Attach updated Immunizations
➢ Sign and date all indicated areas	➢ Chronic condition Plans (if indicated)

- The completed packet can be submitted to the nurse in the following ways:

Hand deliver to the school	**Email your School Nurse**	**Upload to the Link**
KIPP Lanning Square Primary 525 Clinton Street, Camden, NJ, 08103	Nurse Tasha Nurse Kabrina CamdenNurses@kippnj.org	https://tinyurl.com/3f9vqlpj
KIPP Lanning Square Middle 525 Clinton Street, Camden, NJ, 08103		https://tinyurl.com/3f9vqlpj
KIPP Sumner Elementary 1600 S. 8th Street, Camden, NJ, 08104	Nurse Sarah CamdenNurses@kippnj.org	https://tinyurl.com/3f9vqlpj
KIPP Hatch Middle 1875 Park Blvd, Camden, NJ, 08103	Nurse Colleen CamdenNurses@kippnj.org	https://tinyurl.com/3f9vqlpj
KIPP High School 740 Chestnut Street, Camden, NJ, 08103	Nurse Kim CamdenNurses@kippnj.org	https://tinyurl.com/3f9vqlpj

You can also scan this QR code that will take you directly to the above link where you can upload all your health paperwork and let the nurse know if your student(s) have any health concerns that we should be made aware of.

KIPP COOPER NORCROSS

Paquete de Salud

- **Estudiantes nuevos:** Este paquete de salud debe completarse como parte de su inscripción.
- **Estudiantes que regresan:** Deben completer la sección para padres como se describe a continuación. Además, se recomienda que todos los estudiantes obtengan un examen físico actualizado anualmente.
- Consulte la siguiente table para completer
- **Deportes:** TODOS los estudiantes que participen en deportes deben tener un examen físico Deportivo actualizado
- **Niños de 11 años:** Todos los estudiantes de 11 años deben recibir sus vacunas Tdap y meningocócica
- **Asma, alergia, convulsions, diabetes, etc,:** Todos los estudiantes con una condición de salud crónica deben presenter un plan de acción actualizado y los medicamentos deben proporcionarse en el envase original de la farmacia con la etiqueta de la farmacia adjunta

Padres *Debe completer:*	**Pediatra** *Debe completer:*
• Página 2 – Sección 1 • Página 2 – Sección 2 (si se indica)	• Formulario de examen físico
• Página 3 – Escriba sus iniciales en todos las secciones	• Adjunte las vacunas actualizadas
• Firme y feche todos las áreas indicadas	• Planes de condiciones crónicas (si se indica)

- El paquete complete se puede enviar a la enfermera de las siguientes maneras:

Entregar en Mano a la Escuela	**Envie un correo electronico a su enfermera de la Escuela**	**Subir al enlace**
KIPP Lanning Square Primary 525 Clinton Street, Camden, NJ, 08103	Enfermera Tasha Enfermera Kabrina CamdenNurses@kippnj.org	https://tinyurl.com/3f9vqlpj
KIPP Lanning Square Middle 525 Clinton Street, Camden, NJ, 08103		https://tinyurl.com/3f9vqlpj
KIPP Sumner Elementary 1600 S. 8th Street, Camden, NJ, 08104	Nurse Sarah CamdenNurses@kippnj.org	https://tinyurl.com/3f9vqlpj
KIPP Hatch Middle 1875 Park Blvd, Camden, NJ, 08103	Nurse Colleen CamdenNurses@kippnj.org	https://tinyurl.com/3f9vqlpj
KIPP High School 740 Chestnut Street, Camden, NJ, 08103	Nurse Kim CamdenNurses@kippnj.org	https://tinyurl.com/3f9vqlpj

También puede escanear este Código QR que lo llevará directamente al enlace anterior donde puede cargar todos sus documentos de salud y tanbién informarle a la enfermera sis u(s) estudiantes(s) tiene(n) algún problema de salud que debamos conocer.

KIPP COOPER NORCROSS

SCHOOL	GRADE	STUDENT NAME

*NJ STATE SPORTS PHYSICAL ENCLOSED *

KIPP NJ

PHYSICAL FORMS

The forms in this packet must be completed by the parent/guardian AND the Doctor (where applicable)

This physical packet is due:

Returning students: Within 30 days from the first day of school

New students: Within 30 days from registration

We STRONGLY recommend that ALL students get an updated physical every year.

Students with Chronic medical conditions MUST get an updated physical and Treatment plans every year.

Students who will participate in any sports MUST submit a sports physical every year.

KIPP COOPER NORCROSS

A letter from your school nurse

Dear parent/guardian:

We ate KIPP NJ pride ourselves on delivering the best health care possible to each one of our students. It is our mission and joy in life to make sure that when your child walks through our school buildings, that they are not only receiving a quality education, but that they are safe, happy, and healthy!

To achieve this goal of being safe, happy, healthy students, we need YOUR help!

All new incoming students are required to submit the KIPP NJ physical packet as well as updated Immunization records.

Please make sure to set up an appointment for your child well in advance of the first day of school.

If you do not have insurance, you may utilize the free vaccine clinic as listed below:

Immunization Resource

Free Immunizations for residents with no insurance

CamCare Building

817 Federal Street, Camden, NJ (2nd Floor)

Must call for an appointment.

(856) 225-5128

Tuesdays: 8:30 am – 11:30 am and 1:00 pm – 3:00 pm

If you have any questions or concerns about any of the required documents, please feel free to reach out to your school nurse. We will be more than happy to assist you in finding any resources or health services for your child!

KIPP Lanning Square Primary & KIPP Lanning Square Middle	Nurses Tasha and Kabrina	(856) 966-9600
KIPP Sumner Elementary	Nurse Sarah	(856) 263-6240
KIPP Hatch Middle	Nurse Colleen	(856) 359-7046
KIPP High School	Nurse Kim	(856) 263-6235

KIPP COOPER NORCROSS

Parent/Guardian Consent Form

KIPP NJ STUDENT HEALTH INFORMATION & RELEASE

Section 1: GENERAL INFORMATION

Student's Name _____ Date of Birth _____

Parent's Name _____ Phone # _____

May the school nurse contact the student's physician? ☐ Yes ☐ No

May health information be related to the school nurse? ☐ Yes ☐ No

Does the student have health Insurance? ☐ Yes ☐ No

Permission for health information sharing between the school nurse and medical facility/physician office:

I _____ (parent name) hereby consent to the release of _____(student name) health information to the school nurse (including but not limited to: Immunization records, physicals, health condition and related information)

Parent/Guardian Signature _____ Date _____

Section 2: Allergies

Please list all allergies to food, medicine, pollen 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 fees, suits, cause or causes of action which may be brought against the network or its 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 medical treatment for the above-named child, and to release information pertaining to my child's health record, diagnosis, condition, or health history.

Parent/Guardian Signature

_____

Parent/Guardian Signature Date

KIPP COOPER NORCROSS

Parent/Guardian Consent Form

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.

For prescription medications to be given in school, a completed, physician signed medication administration form must be submitted. In addition, students with any chronic condition must submit an action plan (i.e. Asthma Action Plan, Seizure plan etc.).

All prescription medications brought to the school must be in their original pharmacy container and appropriately labeled by the pharmacist. Parents/guardians 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/guardian. 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. Over-the-counter medications are not to be brought into school.

No student is permitted to carry medication with them during the school day unless cleared by a doctor to self-administer. In this case the student must 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 the student to carry their own medication.

Please note that this is for middle and high school students only. Elementary students will not be allowed to self-administer or carry medication during school.

Parent/Guardian initial: _____

Field Trips

Please be advised that the school nurse will not be accompanying the staff and students on field trips. Parents/guardians are responsible to ensure that their child receives their medications during the trip and are properly educated on the use of any prescribed medications treatments that may be needed during the trip. Please note, **Teachers are not able to administer medications.** Parent/Guardian initial: _____

Herbal medications and vitamins

These types of medications will not be given in school Parent/Guardian initial: _____

Routine first aid

The district doctor will provide standing orders yearly for routine first aid and emergency medications as well as over-the-counter items including, but not limited to, eyewash, antiseptic wash, Caladryl which will be used for routine first aid needs.

_____

Parent/Guardian Signature Date

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

PREPARTICIPATION 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 your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have 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 your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your 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 your 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 your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

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

PREPARTICIPATION PHYSICAL EVALUATION

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

Explain "yes" answers here

_____

_____

_____

_____

_____

Please indicate if you have 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 _____

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

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?**
   - **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 of exam _____

Address _____ Phone _____

Signature of physician, APN, PA _____

PREPARTICIPATION 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 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 _____

KIPP COOPER NORCROSS

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.

American Lung Association.

My Asthma **Action Plan**
For Home and School

Name: _____ **DOB:** ____/____/_____

Severity Classification: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Asthma Triggers (list): _____

Peak Flow Meter Personal Best: _____

Green Zone: Doing Well

Symptoms: Breathing is good – No cough or wheeze – Can work and play – Sleeps well at night
Peak Flow Meter _____ (more than 80% of personal best)

Flu Vaccine—Date received: _____ **Next flu vaccine due:** _____ **COVID19 vaccine**—Date received: _____

Control Medicine(s)	Medicine	How much to take	When and how often to take it	Take at
	_____	_____	_____	☐ Home ☐ School
	_____	_____	_____	☐ Home ☐ School

Physical Activity ☐ Use Albuterol/Levalbuterol ____ puffs, 15 minutes before activity ☐ with all activity ☐ when you feel you need it

Yellow Zone: Caution

Symptoms: Some problems breathing – Cough, wheeze, or tight chest – Problems working or playing – Wake at night
Peak Flow Meter _____ to _____ (between 50% and 79% of personal best)

Quick-relief Medicine(s) ☐ Albuterol/Levalbuterol ____ puffs, every 20 minutes for up to 4 hours as needed
Control Medicine(s) ☐ Continue Green Zone medicines
☐ Add _____ ☐ Change to _____

You should feel better within 20-60 minutes of the quick-relief treatment. If you are getting worse or are in the Yellow Zone for more than 24 hours, THEN follow the instructions in the RED ZONE and call the doctor right away!

Red Zone: Get Help Now!

Symptoms: Lots of problems breathing – Cannot work or play – Getting worse instead of better – Medicine is not helping
Peak Flow Meter _____ (less than 50% of personal best)

Take Quick-relief Medicine NOW! ☐ Albuterol/Levalbuterol ____ puffs, _____ (how frequently)

Call 911 immediately if the following danger signs are present:
- Trouble walking/talking due to shortness of breath
- Lips or fingernails are blue
- Still in the red zone after 15 minutes

School Staff: Follow the Yellow and Red Zone instructions for the quick-relief medicines according to asthma symptoms.
The only control medicines to be administered in the school are those listed in the Green Zone with a check mark next to "Take at School".

☐ Both the Healthcare Provider and the Parent/Guardian feel that the child has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

Healthcare Provider
Name _____ Date _____ Phone (____) ____-_____ Signature _____

Parent/Guardian
☐ I give permission for the medicines listed in the action plan to be administered in school by the nurse or other school staff as appropriate.
☐ I consent to communication between the prescribing health care provider or clinic, the school nurse, the school medical advisor and school-based health clinic providers necessary for asthma management and administration of this medicine.

Name _____ Date _____ Phone (____) ____-_____ Signature _____

School Nurse
☐ The student has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

Name _____ Date _____ Phone (____) ____-_____ Signature _____

Please send a signed copy back to the provider listed above. 1-800-LUNGUSA Lung.org

American Lung Association.

How to Use a Metered-Dose Inhaler with a Valved Holding Chamber (Spacer)

Prime a brand-new inhaler: Before using it for the first time, if you have not used it for more than 7 days, or if it has been dropped.

1. Shake inhaler 10 seconds.

2. Take the cap off the inhaler and valved holding chamber. Make sure the mouthpiece and valved holding chamber are clean and there is nothing inside the mouthpieces.

3. Put inhaler into the chamber/spacer.

4. Breathe out away from the device.

5. Put chamber mouthpiece in mouth.

6. Press inhaler once and breathe in deep and steadily.

7. Hold your breath for 10 seconds, then breathe out slowly.

   If you need another puff of medicine, wait 1 minute and repeat steps 4-7.

8. Rinse with water and spit it out.

Proper inhalation technique is important when taking your asthma medicine(s) and monitoring your breathing. Make sure to bring all your medicines and devices to each visit with your primary care provider or pharmacist to check for correct use, or if you have trouble using them.

For more videos, handouts, tutorials and resources, visit Lung.org.

Scan the QR Code to access How-To Videos

You can also connect with a respiratory therapist for one-on-one, free support from the American Lung Association's Lung HelpLine at **1-800-LUNGUSA**.

FARE
Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

PLACE PICTURE HERE

Name: _____ D.O.B.: _____

Allergic 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.

☐ **Special Situation/Circumstance - If this box is checked, the child has an extremely severe allergy to the following food(s)** _____.

Even if the child has MILD symptoms after eating (ingesting) this food(s), Give Epinephrine immediately.

For **ANY** of the following **SEVERE** SYMPTOMS

LUNG
Shortness of breath, wheezing, repetitive cough

HEART
Pale or bluish skin, faintness, weak pulse, dizziness

THROAT
Tight or hoarse throat, trouble breathing or swallowing

MOUTH
Significant swelling of the tongue 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 emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders 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 patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return

MILD SYMPTOMS

NOSE
Itchy or runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea or discomfort

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

FOR **MILD SYMPTOMS** FROM A **SINGLE BODY SYSTEM** (E.G. SKIN, GI, ETC.), 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 or Generic: _____

Epinephrine Dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

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

_____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE

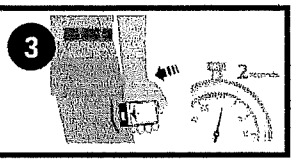
HEALTHCARE PROVIDER AUTHORIZATION SIGNATURE DATE

FARE
Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

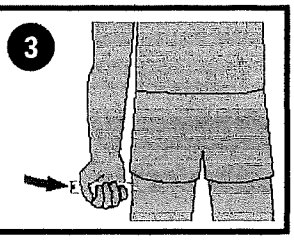
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q® from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q® against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.



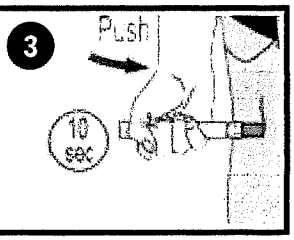
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION

1. (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN
2. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
3. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. *Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.*



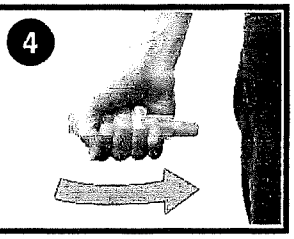
HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip. Grasp the auto-injector in your fist with the red tip pointing downward.
3. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh. Press down hard and hold firmly against the thigh for approximately 10 seconds.
4. Remove and massage the area for 10 seconds. Call 911 and get emergency medical help right away.



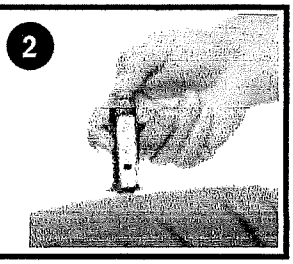
HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE SYMJEPI™ (EPINEPHRINE INJECTION, USP)

1. When ready to inject, pull off cap to expose needle. Do not put finger on top of the device.
2. Hold SYMJEPI™ by finger grips only and slowly insert the needle into the thigh. SYMJEPI™ can be injected through clothing if necessary.
3. After needle is in thigh, push the plunger all the way down until it clicks and hold for 2 seconds.
4. Remove the syringe and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.
5. Once the injection has been administered, using one hand with fingers behind the needle slide safety guard over needle.



ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

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

Epinephrine first, then **call 911.** Monitor the patient and call their emergency contacts right away.

EMERGENCY CONTACTS – CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

SEIZURE ACTION PLAN (SAP)

EPILEPSY FOUNDATION | END EPILEPSY

Name: _____ Birth Date: _____

Address: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Emergency Contact/Relationship _____ Phone: _____

Seizure Information

Seizure Type	How Long It Lasts	How Often	What Happens

Protocol for seizure during school (check all that apply) ☑

- ☐ First aid – **Stay. Safe. Side.**
- ☐ Give rescue therapy according to SAP
- ☐ Notify parent/emergency contact
- ☐ Contact school nurse at _____
- ☐ Call 911 for transport to _____
- ☐ Other _____

First aid for any seizure

- ☐ **STAY** calm, keep calm, **begin timing seizure**
- ☐ Keep me **SAFE** – remove harmful objects, don't restrain, protect head
- ☐ **SIDE** – turn on side if not awake, keep airway clear, don't put objects in mouth
- ☐ **STAY** until recovered from seizure
- ☐ Swipe magnet for VNS
- ☐ Write down what happens _____
- ☐ Other _____

When to call 911

- ☐ Seizure with loss of consciousness longer than 5 minutes, not responding to rescue med if available
- ☐ Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med if available
- ☐ Difficulty breathing after seizure
- ☐ Serious injury occurs or suspected, seizure in water

When to call your provider first

- ☐ Change in seizure type, number or pattern
- ☐ Person does not return to usual behavior (i.e., confused for a long period)
- ☐ First time seizure that stops on its' own
- ☐ Other medical problems or pregnancy need to be checked

When **rescue therapy** may be needed:

WHEN AND WHAT TO DO

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

Care after seizure

What type of help is needed? (describe) _____

When is student able to resume usual activity? _____

Special instructions

First Responders: _____

_____

Emergency Department: _____

_____

Daily seizure medicine

Medicine Name	Total Daily Amount	Amount of Tab/Liquid	How Taken (time of each dose and how much)

Other information

Triggers: _____

Important Medical History _____

Allergies _____

Epilepsy Surgery (type, date, side effects) _____

Device: ☐ VNS ☐ RNS ☐ DBS Date Implanted _____

Diet Therapy ☐ Ketogenic ☐ Low Glycemic ☐ Modified Atkins ☐ Other (describe) _____

Special Instructions: _____

_____

Health care contacts

Epilepsy Provider: _____ Phone: _____

Primary Care: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

Pharmacy: _____ Phone: _____

My signature _____ Date _____

Provider signature _____ Date _____

Epilepsy.com

Revised 01/2020 130SRP/PAB1216

EPILEPSY FOUNDATION

END EPILEPSY

KIPP COOPER NORCROSS

Medication Administration Form

Student	Date of Birth
School	School Year
Teacher	Grade
Parent/Guardian	Phone

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

Name of Medication	MG/MCG/ML/TSP	Take ___ tablet(s) Take ___ tsp	Total MG per dose	Time to take daily or as needed

Reason for medication:

Side effects/precautions:

Start Date: Stop Date:

This student can keep/take this medication on his/her own: Yes No

Note: All controlled/stimulant and/or narcotic medication must be given and supervised by the school nurse for ALL students at ALL grade levels.

Healthcare provider Signature Date

Healthcare provider name (print) Date

TO BE COMPLETED BY PARENT/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 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 provide medication in the original, properly labeled pharmacy container. I will pick up unused/discontinued medication as needed during (or by end of) the school year.

Parent/Guardian Signature Date

Health Office Use Only:

Reviewed by school nurse (Signature) Date