**NJ State law requires written permission from a licensed medical provider and parent before ANY medication is administered in school. Please obtain a medication form(s) from the School Nurse's Office if your child requires medication while in school. All medication is overseen through the School Nurse's Office.**

I certify that the information provided herein is accurate to the best of my knowledge as of the date of my signature. I give consent for my child's health information to be shared on a "need-to-know" basis with faculty/staff and emergency care personnel who may be responsible for my child's care. I give consent for the School Nurse to exchange information with my child's health care provider regarding pertinent health issues. I agree to alert the School Nurse on any changes in medication and/or the health status of my child.

**Printed Parent Name:_________________________**

**Parent Signature: ___________________________**

**Signature Date: _____________________________**

THE COMPLETED AND SIGNED HEALTH HISTORY MUST BE REVIEWED BY THE EXAMINING PROVIDER AT THE TIME OF THE MEDICAL EXAMINATION
### Part II - Physical Evaluation

Completed by the examining licensed provider MD, DO, APN or PA

<table>
<thead>
<tr>
<th>Name</th>
<th>Grade</th>
<th>Gender</th>
<th>Date of Birth</th>
</tr>
</thead>
</table>

#### Findings of Physical Evaluation

- **Height:** 
- **Weight:** 
- **Blood Pressure:** / 
- **Pulse:** bpm  
- **Vision:** R 20/ L 20/ 
- **Contacts:** Y / N  
- **Glasses:** Y / N

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Normal?</th>
<th>Abnormal Findings/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Appearance</td>
<td>YES</td>
<td>Standing makes it: Louder</td>
</tr>
<tr>
<td>Head/Neck</td>
<td>YES</td>
<td>Squatting makes it: Louder</td>
</tr>
<tr>
<td>Eyes/Sclera/Pupils</td>
<td>YES</td>
<td>Valsalva makes it: Louder</td>
</tr>
<tr>
<td>Ears</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Gross Hearing</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Nose/Mouth/Throat/Dental</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Lymph Glands</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Heart Rate</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Rhythm</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Murmur</td>
<td>ABSENT</td>
<td></td>
</tr>
<tr>
<td>If murmur present</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Femoral Pulsus</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Lungs: Auscultation/Percussion</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Chest Contour</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Abdomen (liver, spleen, masses)</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Assessment of Physical Maturation or Tanner</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Testicular Exam (Males Only)</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Neck/Back/Spine:</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Range of Motion</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Scoliosis</td>
<td>ABSENT</td>
<td></td>
</tr>
<tr>
<td>Upper Extremities: (ROM, Strength, Stability)</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Lower Extremities: (ROM, Strength, Stability)</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Neurological: Balance &amp; Coordination</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Hernia</td>
<td>ABSENT</td>
<td></td>
</tr>
<tr>
<td>Evidence of Marfan Syndrome</td>
<td>ABSENT</td>
<td></td>
</tr>
</tbody>
</table>

Most recent immunizations and dates administered (new students please attach full immunization record):

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dosage</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Recent Injuries/Operations/Additional Observations:

General Diagnosis/Medical Concerns:

General Recommendations:

**Conditions requiring clearance before physical education participation include, but are not limited to:** Anaphylaxis; Atlantoaxial instability; Bleeding disorder; Hypertension; Congenital heart disease; Dysrhythmia; Mitral valve prolapse; Heart murmur; Cerebral palsy; Diabetes; Eating disorders; Heat illness history; One-kidney athletes; Hepatomegaly; Splenomegaly; Malignancy; Seizure disorder; Marfan syndrome; History of repeated concussion; Organ transplant recipient; Cystic fibrosis; Sickle cell disease; and/or One-eyed athletes or athletes with vision greater than 20/40 in one eye.

I have examined the above child and reviewed his/her health history prepared by the parent. It is my opinion that he/she is medically cleared to participate in all child care/school activities, including physical education and competitive contact sports without restriction unless noted above.

License Type: MD/DO □ APN □ PA □

Physician’s/Provider’s Name (Print) ____________________________

Physician’s/Provider’s Signature ____________________________

Today’s Date: ___________ Date of Examination: ___________

Licensed Medical Care Provider’s Stamp: ______________________

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(Part II of II) 01/19
Asthma Treatment Plan – Student
(This asthma action plan meets NJ Law N.J.S.A. 18A:46-12.8) (Physician’s Orders)

(Please Print)

Name __________________________ Date of Birth ______________________ Effective Date ____________________

Doctor ______________________ Parent/Guardian (if applicable) __________________________ Emergency Contact ______________________

Phone ______________________ Phone ______________________ 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

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>Advair® HFA O 44b, O 115b, O 230</td>
<td>2 puffs twice a day</td>
</tr>
<tr>
<td>Aerospan™</td>
<td>O 1, O 2 puffs twice a day</td>
</tr>
<tr>
<td>Alvesco® O 80, O 160</td>
<td>O 1, O 2 puffs twice a day</td>
</tr>
<tr>
<td>Dulera® O 100, O 200</td>
<td>2 puffs twice a day</td>
</tr>
<tr>
<td>Flovent® O 44, O 110, O 220</td>
<td>2 puffs twice a day</td>
</tr>
<tr>
<td>Qvar® O 40, O 80</td>
<td>O 1, O 2 puffs twice a day</td>
</tr>
<tr>
<td>Symbicort® O 80, O 160</td>
<td>O 1, O 2 puffs twice a day</td>
</tr>
<tr>
<td>Advair Diskus® O 100, O 250, O 500</td>
<td>1 inhalation every day</td>
</tr>
<tr>
<td>Asmanex® Twisthaler® O 110, O 220</td>
<td>1, 2 inhalations O once or O twice a day</td>
</tr>
<tr>
<td>Flovent® Diskus® O 50 O 100 O 250</td>
<td>1 inhalation every day</td>
</tr>
<tr>
<td>Pulmicort Flexhaler® O 90, O 180</td>
<td>O 1, 2 inhalations O once or O twice a day</td>
</tr>
<tr>
<td>Pulmicort Respules® (Budesonide) O 0.25, O 0.5, O 1.0</td>
<td>1 unit nebulized O once or O twice a day</td>
</tr>
<tr>
<td>Singular® (Montelukast) O 4, O 5, O 10 mg</td>
<td>1 tablet daily</td>
</tr>
</tbody>
</table>

Other: ______________________

If surgery triggers your asthma, take ______________________ puff(s) ______________________ minutes before exercise.

Remember to rinse your mouth after taking inhaled medicine.

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 ______________________

EMERGENCY (Red Zone) !!!
Your asthma is getting worse fast:
- Quick-relief medicine didn’t help within 15-20 minutes
- Breathing is hard or fast
- Nose opens wide • Ribs show
- Trouble walking and talking
- Lips blue • Fingernail blue
- Other: ______________________

And/or Peak flow below ______________________

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>Albuterol MDI (Pro-air® or Proventil® or Ventolin®)</td>
<td>2 puffs every 4 hours as needed</td>
</tr>
<tr>
<td>Xopenex®</td>
<td>2 puffs every 4 hours as needed</td>
</tr>
<tr>
<td>Albuterol O 1.25, O 2.5 mg</td>
<td>1 unit nebulized every 4 hours as needed</td>
</tr>
<tr>
<td>Duoneb®</td>
<td>1 unit nebulized every 4 hours as needed</td>
</tr>
<tr>
<td>Xopenex® (Levalbuterol) O 0.31, O 0.63, O 1.25 mg</td>
<td>1 unit nebulized every 4 hours as needed</td>
</tr>
<tr>
<td>Combivent Respimat®</td>
<td>1 inhalation 4 times a day</td>
</tr>
</tbody>
</table>

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: ______________________

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

This student is not approved to self-medicate.

PHYSICIAN/APN/PA SIGNATURE ______________________

Physician’s Orders

PARENT/GUARDIAN SIGNATURE ______________________

PHYSICIAN STAMP ______________________

Make a copy for parent and for physician file, send original to school nurse or child care provider.
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.

[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

O I do request that my child be ALLOWED to carry the following medication for self-administration in school pursuant to N.J.A.C. 8A: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 tranporting, 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.

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

[Signature]  [Phone]  [Date]
FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: ___________________ Grade: _______ D.O.B.: _______

Diagnosis/Allergic to ___________________________  □ No  □ Yes (higher risk for a severe reaction)

Weight _________ lbs  Asthma:  □  Yes

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

Extremely reactive to the following insects/foods: ___________________________

THEREFORE:

[ ] If checked, give epinephrine immediately for ANY symptoms if the allergen food was likely eaten / or stung

[ ] If checked, give epinephrine immediately if the allergen was definitely eaten / or stung, 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.

MILD SYMPTOMS

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth, a few hives, mild itch

SKIN
Mild rash, sea/ discomfort

GUT
Mild diarrhea

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 auto-injectable dose:

□ 0.15 mg IM  □ 0.3 mg IM

Diphenhydramine (i.e. Benadryl) by mouth

□ 12.5 mg □ 25 mg □ 50 mg □ other ______ mg

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

□ This student is not approved to self-medicate.

□ This student is capable and has been instructed in the proper method of self-administering the initial dose of the auto-injectable epinephrine device named above in accordance with NJ State Law. The student shall carry the medication in the original labeled container noted above at all times in school and at school sponsored activities.

Medical Provider’s stamp with address

Physician/DO/APN/PA Signature  Date
Trained delegates in the administration of initial dose of auto-injectable epinephrine
Name: Location:
Name: Location:
Name: Location:

**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.

Treat someone before calling Emergency Contacts. The first signs of a reaction can be mild, but symptoms can get worse quickly.

<table>
<thead>
<tr>
<th>EMERGENCY CONTACTS — CALL 9-1-1</th>
<th>OTHER EMERGENCY CONTACTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Provider:</td>
<td>Name/Relationship:</td>
</tr>
<tr>
<td>Phone:</td>
<td>Phone:</td>
</tr>
<tr>
<td>Parent/Guardian:</td>
<td>Name/Relationship:</td>
</tr>
<tr>
<td>Phone:</td>
<td>Phone:</td>
</tr>
<tr>
<td>Parent/Guardian:</td>
<td></td>
</tr>
<tr>
<td>Phone:</td>
<td></td>
</tr>
</tbody>
</table>

I give permission for my child to receive medication at school as prescribed in this Food Allergy & Anaphylaxis Emergency Care Plan. Medication shall be provided in its original prescription container and properly labeled by the pharmacist or medical provider. I 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. I understand this information will be shared with school staff on a need-to-know basis. This plan is in effect for the current school year and summer programs.

It is the parents' responsibility to inform the School Nurse when their child will be staying at an after-school sponsored activity. The School Nurse may train volunteers to act as a delegate to administer epinephrine via a pre-filled auto-injector to my child for anaphylaxis or possible anaphylaxis when the School Nurse is not physically present at the scene. I give consent for the trained delegate(s) to administer the initial dose of the epinephrine as indicated.

I acknowledge that Rutgers Preparatory School, Board of Trustees, employees and/or its agents shall incur no liability as a result of any injury arising from the administration (or self-administration, if permitted) of medication to my child. I shall indemnify and hold harmless Rutgers Preparatory School, Board of Trustees, employees, and/or its agents against any claims arising out of the administration (or self-administration, if permitted) of this medication to my child.

☐ I request and give permission for my child to be ALLOWED to carry the above mentioned medication for self-administration as prescribed in this plan.
I consider him/her responsible and capable of self-administering the medication(s) above.

☐ I DO NOT give permission for my child to self administer his/her above mentioned medication(s).

Printed Parent Name: ___________________________ Parent Signature: ___________________________ Date: ___________________________

Rutgers Preparatory School, Somerset, NJ Form adapted from FAAN (www.foodallergy.org) 4-2014
Dear Parent,

Only the School Nurse (or the student's parent) shall administer medication (prescription or over-the-counter) if a student is required to receive medication while attending school or school functions. All medications require written orders from a licensed medical provider and signature from the parent. All medication(s) shall be delivered to the School Nurse by the parent or other designated adult in the original labeled container with the student's name, medication name, medication route, dosage, time and/or other directions, date, and medical provider's name. For prescription medications, please ask the pharmacist to prepare two labeled containers. Herbs and dietary supplements are not considered medications and will not be administered. The parent is responsible to pick up any remaining medication at the end of treatment regime or at the end of the school year or it shall be destroyed seven days after the end of treatment. The only exception for which a student may be permitted to carry and self-administer his/her own medication shall be for a potentially life-threatening illness.

To Be Completed by Licensed Medical Provider:

Student: ___________________________ D.O.B.: ___________ Grade: ___________

Diagnosis: ____________________________________________________________

Name of Medication, Dosage, and Route: __________________________________

Frequency and Indication To Be Administered: ____________________________

Length of Time To Be Given: ____________________________________________

Possible Side Effects: _________________________________________________

__________________________________ Medical Provider's Stamp with Address

Physician/DO/APN/PA Signature

Date __________________________

I hereby request the School Nurse to administer the above medication to my child as prescribed by the medical provider. I give permission for the release and exchange of information between the school nurse and my child's health care providers 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. This authorization is effective for the current school year and summer programs.

I acknowledge that Rutgers Preparatory School, Board of Trustees, employees, and/or its agents shall incur no liability as a result of any injury arising from the administration of medication to my child. I shall indemnify and hold harmless Rutgers Preparatory School, Board of Trustees, employees, and/or its agents against any claims arising out of the administration of medication to my child.

Print Name of Parent

Signature of Parent __________________________ Date 8/21/2015