Preparticipation Physical Evaluation

HISTORY FORM Grades 6-12

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

Date of Exam ____________________________________________________________ Date of birth ____________________________

Name ____________________________ Sex ____________________________ Age ______
School ____________________________ Grade ______

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

<table>
<thead>
<tr>
<th>Medicine/Allergy</th>
<th>Yes</th>
<th>No</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Do you have any allergies? ... Yes ... No ... If yes, please identify specific allergy below.

<table>
<thead>
<tr>
<th>Allergy Type</th>
<th>Yes</th>
<th>No</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

GENERAL QUESTIONS

1. Has a doctor ever denied or restricted your participation in sports for any reason? Yes No

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? Yes No

4. Have you ever had surgery? Yes No

HEART HEALTH QUESTIONS ABOUT YOU

5. Have you ever passed out or nearly passed out during or after exercise? Yes No

6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? Yes No

7. Does your heart ever race or skip beats (irregular beats) during exercise? Yes No

8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: High blood pressure, Heart murmur, High cholesterol, Heart infection, Kawasaki disease, Other: ____________________________

9. Has a doctor ever ordered a test for your heart? (Example, ECG/EKG, echocardiogram) Yes No

10. Do you get lightheaded or feel more short of breath than expected during exercise? Yes No

11. Have you ever had an unexplained seizure? Yes No

12. Do you get more tired or short of breath more quickly than your friends during exercise? Yes No

HEART HEALTH QUESTIONS ABOUT YOUR FAMILY

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)? Yes No

14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arachnodactyly, right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia? Yes No

15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator? Yes No

16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning? Yes No

BONE AND JOINT QUESTIONS

17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game? Yes No

18. Have you ever had any broken or fractured bones or dislocated joints? Yes No

19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches? Yes No

20. Have you ever had a stress fracture? Yes No

21. Have you ever been told that you have or you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfish) Yes No

22. Do you regularly use a brace, orthotics, or other assistive device? Yes No

23. Do you have a bone, muscle, or joint injury that bothers you? Yes No

24. Do any of your joints become painful, swollen, feel warm, or look red? Yes No

25. Do you have any history of juvenile arthritis or connective tissue disease? 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 ____________________________ Date ____________________________

Signature of parent/guardian ____________________________ Date ____________________________

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

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**Preparticipation Physical Evaluation**

**PHYSICAL EXAMINATION FORM**

Name ___________________________ Date of birth ___________________________ *

**PHYSICIAN REMINDERS** *

1. Consider additional questions on more sensitive issues
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - 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).

**EXAMINATION**

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>BP</th>
<th>Pulse</th>
<th>Vision R 20/</th>
<th>L 20/</th>
<th>Corrected</th>
<th>Y</th>
<th>N</th>
<th>NORMAL</th>
<th>ABNORMAL FINDINGS</th>
</tr>
</thead>
</table>

**MEDICAL**

- Appearance
  - Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, am span > height, hyperlaxity, myopia, MVP, aortic insufficiency)

- Eyes/ears/nose/throat
  - Pupils equal
  - Hearing

- Lymph nodes

- Heart
  - Murmurs (auscultation standing, supine, +/- Valsalva)
  - Location of point of maximal impulse (PMI)

- Pulses
  - Simultaneous femoral and radial pulses

- Lungs

- Abdomen

- Genitourinary (males only)*

- Skin
  - HSV, lesions suggestive of MRSA, linea corporis

- Neurologic *

**MUSCULOSKELETAL**

- Neck

- Back

- Shoulder/arm

- Elbow/forearm

- Wrist/hand/fingers

- Hip/hip

- Knee

- Leg/ankle

- Foot/toes

- Functional
  - Duck walk, single leg hop

*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

*Consider G/E 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 ___________________________

Address ___________________________ Phone ___________________________

Signature of physician, APN, PA ___________________________ Date ___________________________ *

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HE0003

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

D-26610/10
**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 _______________________________ Date of Examination *

Completed Cardiac Assessment  Professional Development Module

Date ___________ Signature ____________________________

Asthma Treatment Plan – Student

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

(Please Print)

Name

Date of Birth

Effective Date

Doctor

Parent/Guardian (If applicable)

Emergency Contact

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 it</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advair® HFA</td>
<td>2 puffs twice a day</td>
</tr>
<tr>
<td>Aerospan™</td>
<td>1, 2 puffs twice a day</td>
</tr>
<tr>
<td>Alvesco®</td>
<td>1, 2 puffs twice a day</td>
</tr>
<tr>
<td>Dulera®</td>
<td>2 puffs twice a day</td>
</tr>
<tr>
<td>Flovent®</td>
<td>2 puffs twice a day</td>
</tr>
<tr>
<td>Quvar®</td>
<td>1, 2 puffs twice a day</td>
</tr>
<tr>
<td>Symbicort®</td>
<td>1, 2 puffs twice a day</td>
</tr>
<tr>
<td>Advair Diskus®</td>
<td>1 inhalation twice a day</td>
</tr>
<tr>
<td>Asmanex® Twilisher®</td>
<td>1, 2 inhalations once or twice a day</td>
</tr>
<tr>
<td>Flovent® Diskus®</td>
<td>1 inhalation once a day</td>
</tr>
<tr>
<td>Pulmicort Flexhaler®</td>
<td>1, 2 inhalations once or twice a day</td>
</tr>
<tr>
<td>Pulmicort Respules® (Budesonide)</td>
<td>0.25, 0.5, 1.0</td>
</tr>
<tr>
<td>Singular® (Montelukast)</td>
<td>4, 5, 10 mg</td>
</tr>
</tbody>
</table>

And/or Peak flow above

If exercise 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 to

<table>
<thead>
<tr>
<th>MEDICINE</th>
<th>HOW MUCH to take and HOW OFTEN to take it</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 1.25, 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) 0.31, 0.63, 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>

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

EMERGENCY (Red Zone)

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

And/or

Peak flow below

<table>
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<td>1 inhalation 4 times a day</td>
</tr>
<tr>
<td>Other:</td>
<td></td>
</tr>
</tbody>
</table>

Take these medicines NOW and CALL 911.

Asthma can be a life-threatening illness. Do not wait!

Permission to Self-administer Medication:
• This student is capable and has been instructed in the proper method of self-administering the non-nebulized inhaled 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.

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 (1) SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY

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

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

Parent/Guardian Signature ____________________________________________________________
Phone ___________________________ Date __________________________
Name: ___________________________ Grade: ________ D.O.B: ____________

Diagnosis/Allergic to ____________________________________________________________

Weight ______ lbs Asthma: □ Yes (higher risk for a severe reaction)

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

Extremely reactive to the following insects/foods: ____________________________

THEFORE:
[ ] 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.

1. INJECT EPINEPHRINE IMMEDIATELY.
2. Call 911. Tell them the child is having anaphylaxis and may need epinephrine when they arrive.
   • Consider giving additional medications following epinephrine:
     » Antihistamine
     » Inhaler (bronchodilator) if wheezing
   • Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
   • If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
   • Alert emergency contacts.
   • Transport them to ER even if symptoms resolve. Person should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/discomfort

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

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

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

MEDICATIONS/DOSES

Epinephrine auto-injectable dose:
☐ 0.15 mg IM ☐ 0.3 mg IM

Diphenhydramine (i.e. Benadryl) by mouth
☐ 12.5 mg ☐ 25 mg ☐ 50mg ☐ 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.

---

**EMERGENCY CONTACTS — CALL 9-1-1**

<table>
<thead>
<tr>
<th>Medical Provider:</th>
<th>Phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent/Guardian:</td>
<td>Phone:</td>
</tr>
<tr>
<td>Parent/Guardian:</td>
<td>Phone:</td>
</tr>
</tbody>
</table>

**OTHER EMERGENCY CONTACTS**

<table>
<thead>
<tr>
<th>Name/Relationship:</th>
<th>Phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name/Relationship:</td>
<td>Phone:</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: _____________________________________________________

Physician/DO/APN/PA Signature ____________________________________________

Medical Provider’s Stamp with Address

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

1345 Easton Avenue • Somerset, New Jersey 08873 • (732) 545-5600 • Fax (732) 745-2685