HISTORY

Must be completed by Student and Parent

Date of Exam ___________________________ Date of birth _____________________________

Name ___________________________ 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

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 ... Arthritis ... Diabetes ... Infections ... Other: ___________________________
   Yes ________ No ________

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 ... A heart murmur ... High cholesterol ... A heart infection ... Kawasaki disease ... Other: ___________________________
   Yes ________ No ________

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

10. Do you feel 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, arrhythmogenic 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 have had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)
    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 ___________________________ Signature of parent/guardian ___________________________ Date ____________


HISTORY 0113

SL-7LYZ"+LHRJ7LJUVM_K7HJ7U4"7YZHYJF7J32013.71
NEW JERSEY HEALTH REQUIREMENTS FOR SCHOOL ATTENDANCE

It is a New Jersey law that a student must have a health physical evaluation by a New Jersey licensed medical provider. A school representative and/or your homestay family will help you arrange for your physical evaluation once you arrive to New Jersey.

What do I need to bring with me when I have my health physical examination performed by a medical provider in the United States?

- Medical History Form completed by your parent prior to your physical evaluation in NJ (see attachment)
- Immunization Record
- Health History Booklet for Travel (if you have one)
- TB Screening Test Results

<table>
<thead>
<tr>
<th>Required Medical Screenings</th>
<th>Meets Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuberculosis (TB/Mantoux) Screening Test</td>
<td>Documentation of a Tuberculosis (TB/Mantoux) screening test performed in the last six months. If the results were positive the follow up chest x-ray report is also required.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Required Immunizations</th>
<th>Meets Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTP</td>
<td>3 doses</td>
</tr>
</tbody>
</table>
| Tetanus, Diphtheria, Acellular Pertussis (Tdap) | 1 dose of Tdap if born on or after 1/1/97 and entering or attending Grade 6 or higher  
  *Given no earlier than the 10th birthday  
  *Children who received a Td booster dose within the past 5 years shall not be required to receive Tdap until five years from the last DTP, DTaP or Td  
  * Children born on or after January 1, 1997, and transferring into a New Jersey school from another state or country, shall have received one dose of Tdap, provided at least five years have elapsed from the last documented Td dose |
| Polio                  | 3 doses  
  Note: 18 years of age or older not required |
| Measles                | 2 doses  
  Note: both must be on or after the first birthday and at least one month apart OR laboratory evidence of immunity |
| Mumps                  | 1 dose on or after first birthday OR laboratory evidence of immunity |
| Rubella/German Measles | 1 dose on or after first birthday OR laboratory evidence of immunity |
| Hepatitis B            | 3 doses  
  OR laboratory evidence of immunity |
| Varicella/Chicken Pox  | 1 dose after the first birthday if born after 1/1/98  
  OR laboratory evidence of immunity  
  OR healthcare provider or parental written statement of previous varicella/chicken pox disease |
| Meningococcal Conjugate Vaccine (MCV4) | 1 dose if born on or after 1/1/97 and entering or attending Grade 6 or comparable unassigned grade  
  * Every child born on or after January 1, 1997, and transferring into a New Jersey school from another state or country on or after September 1, 2008, shall have received one dose of meningococcal vaccine.  
  *Applies to students when they turn 11 years old |
Asthma Treatment Plan – Student

(Please Print)

Name ____________________________ Date of Birth ____________

Effective Date ____________

Doctor ____________________________ Parent/Guardian (if applicable) ____________________________

Phone ____________________________ Phone ____________________________

Emergency Contact ____________________________

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 45, 115, 230</td>
<td>2 puffs twice a day</td>
</tr>
<tr>
<td>AeroS®</td>
<td>1</td>
</tr>
<tr>
<td>Alvesco® 80, 160</td>
<td>1</td>
</tr>
<tr>
<td>Dulera® 100, 200</td>
<td>2 puffs twice a day</td>
</tr>
<tr>
<td>Flovent® 44, 110, 220</td>
<td>2 puffs twice a day</td>
</tr>
<tr>
<td>Qvar® 40, 80</td>
<td>1</td>
</tr>
<tr>
<td>Symbicort® 80, 160</td>
<td>1</td>
</tr>
<tr>
<td>Advair Diskus® 100, 250, 500</td>
<td>1 inhalation twice a day</td>
</tr>
<tr>
<td>Asmanex® Twidhaler® 110, 220</td>
<td>1</td>
</tr>
<tr>
<td>Flovent® Diskus® 50, 100, 250</td>
<td>1 inhalation twice a day</td>
</tr>
<tr>
<td>Pulmicort Flexhaler® 90, 180</td>
<td>1</td>
</tr>
<tr>
<td>Pulmicort Respules® (Budesonide) 0.25, 0.5, 1.0</td>
<td>1 unit nebulized once or twice a day</td>
</tr>
<tr>
<td>Singular® (Montelukast) 4, 5, 10 mg</td>
<td>1 tablet daily</td>
</tr>
</tbody>
</table>

If exercise triggers your asthma, take ____________________________ puffs ____________________________ minutes before exercise.

Remember to rinse your mouth after taking inhaled medicine.

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 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>

Increase the dose of, or add:

Other: ____________________________

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

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 it</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albuterol MDI (Pro-air® or Proventil® or Ventolin®)</td>
<td>4 puffs every 20 minutes</td>
</tr>
<tr>
<td>Xopenex®</td>
<td>4 puffs every 20 minutes</td>
</tr>
<tr>
<td>Albuterol 1.25, 2.5 mg</td>
<td>1 unit nebulized every 20 minutes</td>
</tr>
<tr>
<td>Duoneb®</td>
<td>1 unit nebulized every 20 minutes</td>
</tr>
<tr>
<td>Xopenex® (Levalbuterol) 0.31, 0.63, 1.25 mg</td>
<td>1 unit nebulized every 20 minutes</td>
</tr>
<tr>
<td>Combivent Respimat®</td>
<td>1 inhalation 4 times a day</td>
</tr>
</tbody>
</table>

This asthma treatment plan is meant to assist, not replace, the clinical decision-making required to meet individual patient needs.
Asthma Treatment Plan – Student
Parent Instructions

The PACNJ Asthma Treatment Plan is designed to help everyone understand the steps necessary for the individual student to achieve the goal of controlled asthma.

1. Parents/Guardians: Before taking this form to your Health Care Provider, complete the top left section with:
   - Child’s name
   - Child’s date of birth
   - Child’s doctor’s name & phone number
   - An Emergency Contact person’s name & phone number
   - Parent/Guardian’s name & phone number

2. Your Health Care Provider will complete the following areas:
   - The effective date of this plan
   - The medicine information for the Healthy, Caution and Emergency sections
   - Your Health Care Provider will check the box next to the medication and check how much and how often to take it
   - Your Health Care Provider may check “OTHER” and:
     - Write in asthma medications not listed on the form
     - Write in additional medications that will control your asthma
     - Write in generic medications in place of the name brand on the form
   - Together you and your Health Care Provider will decide what asthma treatment is best for your child to follow

3. Parents/Guardians & Health Care Providers together will discuss and then complete the following areas:
   - Child’s peak flow range in the Healthy, Caution and Emergency sections on the left side of the form
   - Child’s asthma triggers on the right side of the form
   - Permission to Self-administer Medication section at the bottom of the form: Discuss your child’s ability to self-administer the inhaled medications, check the appropriate box, and then both you and your Health Care Provider must sign and date the form

4. Parents/Guardians: After completing the form with your Health Care Provider:
   - Make copies of the Asthma Treatment Plan and give the signed original to your child’s school nurse or child care provider
   - Keep a copy easily available at home to help manage your child’s asthma
   - Give copies of the Asthma Treatment Plan to everyone who provides care for your child, for example: babysitters, before/after school program staff, coaches, scout leaders

Parent Authorization

I hereby give permission for my child to receive medication at school as prescribed in the Asthma Treatment Plan. Medication must be provided in its original prescription container properly labeled by a pharmacist or physician. I also give permission for the release and exchange of information between the school nurse and my child’s health care provider concerning my child’s health and medications. In addition, I understand that this information will be shared with school staff on a need to know basis.

Parent/Guardian Signature ____________________________ Phone ____________________________ Date ____________

FILL OUT THE SECTION BELOW ONLY IF YOUR HEALTH CARE PROVIDER CHECKED PERMISSION FOR YOUR CHILD TO SELF-ADMINISTER ASTHMA MEDICATION ON THE FRONT OF THIS FORM.

RECOMMENDATIONS ARE EFFECTIVE FOR ONE (1) SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY

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

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

Parent/Guardian Signature ____________________________ Phone ____________________________ Date ____________

Disclaimer: The use of this website/PACNJ Asthma Treatment Plan and its content is at your own risk. The content is provided “as is” basis. The American Lung Association of the NEA Atlantic (ALAM-A), the Pediatric/Adult Asthma Coalition of New Jersey, and all 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’ rights, and fitness for a particular purpose. ALAM-A makes no representation or warranty about the accuracy, reliability, completeness, currency, or otherwise content. ALAM-A reserves the right to modify or remove the content at any time. ALAM-A makes no warranty, representation or guarantee that the information will be underwritten in error of any defects that may be found. The content shall be used for informational purposes only. The release, exchange or use of this content for any purpose is at one’s own risk. ALAM-A and its affiliates are not liable for any claim, whatsoever, caused by your use or misuse of the Asthma Treatment Plan, nor of this website.
FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: ___________________________ Grade: _______________ D.O.B.: ___________________

Diagnosis/Allergic to ___________________________ D.O.B.: ___________________

Weight ________ lbs Asthma: □ No □ 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: __________________________________________

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 is about to happen, anxiety, confusion

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

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: ______________________

EPY-PEN® (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.

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 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