**2017-2018 GRADES PK-5 ANNUAL PHYSICAL EXAMINATION FORM**

ANNUAL PHYSICAL EXAMINATIONS MUST BE PERFORMED AFTER MARCH 1, 2017 and ARE DUE by TUESDAY, AUGUST 1, 2017 to the School Nurse’s Office

Please mail, e-mail: nurse@rutgersprep.org, or fax: (732) 745-2685

Name: __________________________ Gender: M F Grade: ______ Date of Birth: / / 

Medical Care Provider’s Name: __________________________ Phone: __________________________ Fax: __________________________

### Part I - Health History Questionnaire - To Be Completed by Parent Before Physical Evaluation

Does your child currently or in the past, have any of the following conditions? Please complete the following checklist giving details and year when illness/injury occurred.

<table>
<thead>
<tr>
<th>Allergies: Medications, Food or Seasonal</th>
<th>Yes</th>
<th>No</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy to Bee / Insect Sting (Severe reaction requiring Emergency Epinephrine)</td>
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<tr>
<td>ADD / ADHD</td>
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<tr>
<td>Anemia / Sickle Cell</td>
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<tr>
<td>Arthritis</td>
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<tr>
<td>Asthma / Reactive Airway Disease</td>
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<tr>
<td>Back / Neck Injury</td>
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<td></td>
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<tr>
<td>Blood / Clotting Disorder</td>
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<tr>
<td>Cancer / Leukemia</td>
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<tr>
<td>Chickenpox-disease date</td>
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<tr>
<td>Dental Problems</td>
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<tr>
<td>Depression</td>
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<tr>
<td>Diabetes</td>
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<tr>
<td>Head Injury / Concussion</td>
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<tr>
<td>Headaches / Migraines</td>
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<tr>
<td>Hearing Deficit / Ear Tubes</td>
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<tr>
<td>Heart Condition / Murmur / Rheumatic Fever / Blood Pressure</td>
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<tr>
<td>Hepatitis</td>
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<tr>
<td>Hernia</td>
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<tr>
<td>Kidney / Bladder Disorder</td>
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<tr>
<td>Lung Disease / TB / Pertussis</td>
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<tr>
<td>Lyme Disease</td>
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<tr>
<td>Mononucleosis</td>
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<tr>
<td>Orthopedic Problems / Fractures</td>
<td></td>
<td></td>
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<tr>
<td>Physical Disability / Activity Restrictions</td>
<td></td>
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<tr>
<td>Seizure Disorder</td>
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<tr>
<td>Surgery</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Speech Problems / Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision Impairment / Glasses / Contacts</td>
<td></td>
<td></td>
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<tr>
<td>Other: (explain below)</td>
<td></td>
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</table>

Explain other illness/health conditions and all “yes” answers listed above including relevant dates:

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**Part II-Physical Evaluation-Completed by the examining licensed provider MD, DO, APN or PA**

Name ___________________________ Grade ___________________________ Gender M F Date of Birth ________________

### **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></td>
</tr>
<tr>
<td>Head/Neck</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Eyes/Sclera/Pupils</td>
<td>YES</td>
<td></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>Standing makes it: Louder Softer No Change</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Squatting makes it: Louder Softer No Change</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Valsalva makes it: Louder Softer No Change</td>
</tr>
<tr>
<td>Femoral Pulses</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>
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</tbody>
</table>

Medications currently prescribed, with dose and frequency:

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
- Dysrythmia
- 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
- Any 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: ___________________________

(Part II of II)
AUTHORIZATION TO RELEASE AND EXCHANGE CONFIDENTIAL INFORMATION

Name of Student: ___________________________ Date of Birth (M/D/Y) ___________ Grade ________
First M Last

I hereby authorize the School Nurse, Rutgers Preparatory School, 1345 Easton Avenue, Somerset, NJ 08873
(732) 545-5600

and

Name and Address of Agency ___________________________

Phone: ( ) ___________________

to exchange health and educational information/records from the above-named child's records for the purpose listed
below.

Requested health/educational information to be disclosed:
€ Any or all necessary health/educational information: or
€ Specific health/educational information to be disclosed consists of: ________________________________

____________________________________________________

This information will be used for the following purpose(s):
1. Educational evaluation and program planning
2. Health assessment and planning for health care services and treatment in school
3. Medical evaluation and treatment
4. Other: ________________

I authorize the Rutgers Preparatory School Health Services nursing staff to share any health information, on a "need-
to-know" basis, with school personnel who may be responsible for my child.

This authorization is valid for one calendar year from date of signing the release form. I may revoke this
authorization at any time by submitting written notice of the withdrawal of my consent and deliver to the health care
person(s) listed above. I recognize that health records, once received by Rutgers Preparatory School will become
education records protected by the Family Educational Rights and Privacy Act. I also understand that if I refuse to
sign, such refusal will not interfere with my child's ability to obtain health care.

_____________________________                ___________________________
Print Name                                           Date

Signature of Parent

6-14
Asthma Treatment Plan – Student

This asthma action plan meets NJ Law N.J.S.A. 18A:48-12.8 (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

And/or Peak flow above

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

MEDICINE

Advair® HFA [45, 115, 230] 
Aerospan®
Alvesco® 80, 160
Duerx® 100, 200
Flovent® 44, 110, 220
Glar® 40, 80
Symbicort® 80, 160
Advair Diskus® 100, 250, 500
Asmanex® Twisterhaler® 110, 220
Flovent® Diskus® 50, 100, 250
Pulmicort Flexhaler® 90, 180
Pulmicort Respules® (Budesonide) 0.25, 0.5, 1.0
Singular® (Montelukast) 4, 5, 10 mg

HOW MUCH to take and HOW OFTEN to take it
2 puffs twice a day
1 puff twice a day
2 puffs twice a day
2 puffs twice a day
2 puffs twice a day
1 inhalation twice a day
1 inhalation twice a day
1 inhalation twice a day
1 tablet daily

Remember to rinse your mouth after taking inhaled medicine.

If exercise triggers your asthma, take

puff(s) minutes before exercise.

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

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

MEDICINE

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

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 • Ribs show
• Trouble walking and talking
• Lips blue • Fingernails blue
• Other:

And/or Peak flow below

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

MEDICINE

Albuterol MDI (Pro-air® or Proventil® or Ventolin®) 4 puffs every 20 minutes
Xopenex® 4 puffs every 20 minutes
Albuterol 1.25, 2.5 mg 1 unit nebulized every 20 minutes
Duoneb® 1 unit nebulized every 20 minutes
Xopenex® (Levalbuterol) 0.31, 0.63, 1.25 mg 1 unit nebulized every 20 minutes
Combivent Respimat® 1 inhalation 4 times a day
Other:

Permission to Self-administer Medication:

☐ This student is capable and has been instructed in the proper method of self-administering of 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: 

Save
Print

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

Date ___

Print Medicines Only
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
   - Parent/Guardian's name
   - An Emergency Contact person'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]
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 by this medication by the student.

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

[Signature]
Parent/Guardian Signature

[Phone]

[Date]

The Pediatric/Adult Asthma Coalition of New Jersey

"Your Pathway to Asthma Control"
PACNJ Approved Plan available at www.pacnj.org

Sponsored by

American Lung Association

In New Jersey

"Your Pathway to Asthma Control"
PACNJ Approved Plan available at www.pacnj.org

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**FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN**

Name: ___________________________ Grade: _______ D.O.B.: ________

Diagnosis/Allergic to ___________________________  

[ ] No  

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: ___________________________.

**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**  
  Swelling of the lips, tongue and/or oral cavity  

- **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  

- **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**
Medical Provider: ____________________________ Phone: ____________________________
Parent/Guardian: ____________________________ Phone: ____________________________

**OTHER EMERGENCY CONTACTS**
Name/Relationship: ____________________________ Phone: ____________________________
Name/Relationship: ____________________________ Phone: ____________________________

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
Rutgers Preparatory School

Medication Form

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 ____________

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