MEDICAL DOCUMENTS

IMPORTANT MEDICAL DOCUMENTS THAT MUST BE COMPLETED BY PHYSICIAN AND PARENT/GUARDIAN PRIOR TO REGISTRATION.

This packet includes:

- IMMUNIZATIONS REQUIRED FOR PREK
- FLU SHOT DUE DATE 10/31/21
- UNIVERSAL CHILD HEALTH RECORD (CURRENT CALENDAR YEAR)
- JCBOE HEALTH HISTORY QUESTIONNAIRE
- FOOD ALLERGY ACTION PLAN (only if applicable to your child)
- ASTHMA TREATMENT PLAN (only if applicable to your child)
Summary of NJ Child Care/Preschool Immunization Requirements

Listed in the chart below are the minimum required number of doses your child must have to attend a NJ child care/preschool.* This is strictly a summary document. Exceptions to these requirements (i.e. provisional admission, grace periods, and exemptions) are specified in the Immunization of Pupils in School rules, New Jersey Administrative Code (N.J.A.C. 8:57-4). Please reference the administrative rules for more details [https://www.nj.gov/health/ed/imm_requirements/acode/](https://www.nj.gov/health/ed/imm_requirements/acode/). Additional vaccines are recommended by Advisory Committee on Immunization Practices (ACIP) for optimal protection. For the complete ACIP Recommended Immunization Schedule, please visit [http://www.cdc.gov/vaccines/schedules/index.html](http://www.cdc.gov/vaccines/schedules/index.html).

<table>
<thead>
<tr>
<th>At this age the child should have received the following vaccines:</th>
<th>2 months</th>
<th>4 months</th>
<th>6 months</th>
<th>12 months</th>
<th>15 months</th>
<th>18 months</th>
<th>19 months</th>
<th>20-59 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphtheria, tetanus &amp; acellular pertussis (DTaP)</td>
<td>Dose #1</td>
<td>Dose #2</td>
<td>Dose #3</td>
<td></td>
<td>Dose #4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inactivated Poliovirus (Polio)</td>
<td>Dose #1</td>
<td>Dose #2</td>
<td></td>
<td></td>
<td>Dose #3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Haemophilus influenzae</em> type b (Hib)</td>
<td>Dose #1</td>
<td>Dose #2</td>
<td></td>
<td>1-4 doses¹ (see footnote)</td>
<td></td>
<td></td>
<td>At least 1 dose given on or after the first birthday</td>
<td></td>
</tr>
<tr>
<td>Pneumococcal conjugate (PCV 13)</td>
<td>Dose #1</td>
<td>Dose #2</td>
<td></td>
<td>1-4 doses¹ (see footnote)</td>
<td></td>
<td></td>
<td>At least 1 dose given on or after the first birthday</td>
<td></td>
</tr>
<tr>
<td>Measles, mumps, rubella (MMR)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Dose #1²</td>
</tr>
<tr>
<td>Varicella (VAR)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Dose #1³</td>
</tr>
<tr>
<td>Influenza (IIV; LAIV)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>One dose due each year¹</td>
</tr>
</tbody>
</table>

*Interpretation: Children need to receive the minimum number of age-appropriate vaccines prior to entering child care/preschool. For example, a child 2 months of age, must have 1 dose each of DTaP, Polio, Hib, and PCV before being permitted to enter child care/preschool. A child entering at a younger age range than listed above must have proof of receiving vaccines in the previous age bracket. Example: A child entering child care/preschool at 11 months of age, would need at least the following: 3 DTaP, 2 Polio, 2 Hib, and 2 PCV. If a child has not received any vaccines, he/she would need at least one dose of each required vaccine to enter school provisionally and be in the process of receiving the remaining doses as rapidly and as medically feasible. The current seasonal flu vaccine is required every year by December 31 for children 6-59 months of age.
FOR CHILD CARE/PRESCHOOL DIRECTORS AND PARENTS: IMMUNIZATION REQUIREMENTS

† *Haemophilus influenzae* type b (Hib) and *pneumococcal* (PCV) vaccines are special cases. If a child started late with these vaccines he/she may need fewer doses. One dose of each is required on or after the first birthday in all cases.

Please Note: The use of combination vaccines may allow students to receive the 1st birthday booster dose of Hib between 15-18 months of age.

‡ **MMR vaccine may be given as early as 12 months of age**, but NJ **requires** children to receive the vaccine by 15 months of age. Prior to age 15 months, a child may enter preschool/child care without a documented dose of MMR.

§ **Varicella vaccine may be given as early as 12 months of age**, but NJ **requires** children to receive the vaccine by 19 months of age. Prior to age 19 months, a child may enter preschool/child care without a documented dose of varicella. A child will not have to receive the varicella vaccine if he/she previously had chickenpox as long as the parent can provide the school with one of the following: 1. documented laboratory evidence showing immunity (protection) from chickenpox, 2. a physician’s **written** statement that the child previously had chickenpox, or 3. a parent’s **written** statement that the child previously had chickenpox.

¶ **Seasonal Flu**: The current seasonal influenza vaccine is required every year for those children 6 months through 59 months of age. Students who have not received the flu vaccine by December 31 must be excluded (not allowed to attend child care/preschool) for the duration of influenza season (through March 31), until they receive at least one dose of the influenza vaccine or until they turn 60 months of age. Children entering child care/preschool after December 31, must provide documentation of receiving the current seasonal flu vaccine. Students entering child care/preschool after March 31 are not required to receive the flu vaccine; however, flu season may extend until May and therefore getting a flu vaccine even late in the season is still protective.

**NOTE:** NJ also accepts valid medical and religious exemptions (reasons for not showing proof of immunizations) as per the NJ Immunization of Pupils in School regulations, (N.J.A.C. 8:57-4). Children without proof of immunity as defined by ACIP, including those with medical and religious exemptions, may be excluded from a school, preschool, or child care facility during a vaccine preventable disease outbreak or threatened outbreak as determined by the Commissioner, Department of Health or his or her designee. In addition, anybody having control of a school may, on account of the prevalence of any communicable disease, or to prevent the spread of communicable disease, prohibit the attendance of any teacher or pupil of any school under their control and specify the time during which the teacher or scholar shall remain away from school. The Department of Health shall provide guidance to the school of the appropriateness of any such prohibition.

For more information, please visit “NJ Immunization Requirements Frequently Asked Questions”, at the following link:
https://nj.gov/health/ed/imm_requirements/

*Interpretation: Children need to receive the minimum number of age-appropriate vaccines prior to entering child care/preschool. For example, a child 2 months of age, must have 1 dose each of DTaP, Polio, Hib, and PCV before being permitted to enter child care/preschool. A child entering at a younger age range than listed above must have proof of receiving vaccines in the previous age bracket. Example: A child entering child care/preschool at 11 months of age, would need at least the following: 3 DTaP, 2 Polio, 2 Hib, and 2 PCV. If a child has not received any vaccines, he/she would need at least one dose of each required vaccine to enter school provisionally and be in the process of receiving the remaining doses as rapidly and as medically feasible. The current seasonal flu vaccine is required every year by December 31 for children 6-59 months of age.

Updated: 9/2020
GROWING TREE LEARNING CENTER
27 FISK STREET
JERSEY CITY, NJ 07305

INFLUENZA VACCINE DUE OCTOBER 31, 2021

The State of New Jersey requires children six months through 59 months of age attending any licensed Preschool to annually receive the influenza vaccine. We strongly recommend that children are vaccinated as soon as your health care provider has the vaccination available in their office; most preferably before flu season.

According to the law, if your pre-k child does not receive the flu vaccine by the end of the calendar year, he/she must be excluded from school.

There is no grace period given for unvaccinated children after December 31, 2021.

I have read the guidelines for Influenza vaccination and will abide by these requirements.

Child’s Name: ____________________________________________

Parent’s Name: __________________________________________

Signature: ___________________________ Date: ________________
### SECTION I - TO BE COMPLETED BY PARENT(S)

- **Child’s Name (Last):**
- **(First):**
- **Gender:**
  - Male
  - Female
- **Date of Birth:** / /
- **Does Child Have Health Insurance?**
  - Yes
  - No
- **If Yes, Name of Child’s Health Insurance Carrier:**
- **Parent/Guardian Name:**
- **Home Telephone Number:** ( ) -
- **Work Telephone/Cell Phone Number:** ( ) -
- **Parent/Guardian Name:**
- **Home Telephone Number:** ( ) -
- **Work Telephone/Cell Phone Number:** ( ) -

I give my consent for my child’s Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

**Signature/Date:**

This form may be released to WIC.

- **Yes**
- **No**

### SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

- **Date of Physical Examination:**
- **Results of physical examination normal?**
  - Yes
  - No
- **Abnormalities Noted:**
- **Weight (must be taken within 30 days for WIC):**
- **Height (must be taken within 30 days for WIC):**
- **Head Circumference (if <2 Years):**
- **Blood Pressure (if ≥3 Years):**

### IMMUNIZATIONS

- **Immunization Record Attached:**
- **Date Next Immunization Due:**

### MEDICAL CONDITIONS

- **Chronic Medical Conditions/Related Surgeries**
  - List medical conditions/ongoing surgical concerns:
  - None
  - Special Care Plan Attached
- **Medications/Treatments**
  - List medications/treatments:
  - None
  - Special Care Plan Attached
- **Limitations to Physical Activity**
  - List limitations/special considerations:
  - None
  - Special Care Plan Attached
- **Special Equipment Needs**
  - List items necessary for daily activities:
  - None
  - Special Care Plan Attached
- **Allergies/Sensitivities**
  - List allergies:
  - None
  - Special Care Plan Attached
- **Special Diet/Vitamin & Mineral Supplements**
  - List dietary specifications:
  - None
  - Special Care Plan Attached
- **Behavioral Issues/Mental Health Diagnosis**
  - List behavioral/mental health issues/concerns:
  - None
  - Special Care Plan Attached
- **Emergency Plans**
  - List emergency plan that might be needed and the signs/symptoms to watch for:
  - None
  - Special Care Plan Attached

### PREVENTIVE HEALTH SCREENINGS

<table>
<thead>
<tr>
<th>Type Screening</th>
<th>Date Performed</th>
<th>Record Value</th>
<th>Type Screening</th>
<th>Date Performed</th>
<th>Note if Abnormal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hgb/Hct</td>
<td>Hearing</td>
<td></td>
<td>Vision</td>
<td>Dental</td>
<td>Scoliosis</td>
</tr>
<tr>
<td>Lead:</td>
<td>Capillary</td>
<td>Venous</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TB (mm of Induration)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td>Other:</td>
<td>Developmental</td>
<td></td>
</tr>
</tbody>
</table>

- **I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.**

- **Signature/Date:**

**Health Care Provider Stamp:**

**Distribution:** Original-Child Care Provider Copy-Parent/Guardian Copy-Health Care Provider
Instructions for Completing the Universal Child Health Record (CH-14)

Section 1 - Parent

Please have the parent/guardian complete the top section and sign the consent for the child care provider/school nurse to discuss any information on this form with the health care provider.

The WIC box needs to be checked only if this form is being sent to the WIC office. WIC is a supplemental nutrition program for Women, Infants and Children that provides nutritious foods, nutrition counseling, health care referrals and breast feeding support to income eligible families. For more information about WIC in your area call 1-800-328-3838.

Section 2 - Health Care Provider

1. Please enter the date of the physical exam that is being used to complete the form. Note significant abnormalities especially if the child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing etc.)
   - Weight - Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within the last 30 days.
   - Height - Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within the last 30 days.
   - Head Circumference - Only enter if the child is less than 2 years.
   - Blood Pressure - Only enter if the child is 3 years or older.

2. Immunization - A copy of an immunization record may be copied and attached. If you need a blank form on which to enter the immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Department of Health, Vaccine Preventable Diseases Program at 609-826-4860. The immunization record must be attached for the form to be valid.
   - "Date next immunization is due" is optional but helps child care providers to assure that children in their care are up-to-date with immunizations.

3. Medical Conditions - Please list any ongoing medical conditions that might impact the child's health and well being in the child care or school setting.
   a. Note any significant medical conditions or major surgical history. If the child has a complex medical condition, a special care plan should be completed and attached for any of the medical issue blocks that follow. A generic care plan (CH-15) can be downloaded at www.nj.gov/health/forms/ch-15.dot or pdf. Hard copies of the CH-15 can be requested from the Division of Family Health Services at 609-292-5666.
   b. Medications - List any ongoing medications. Include any medications given at home if they might impact the child's health while in child care (seizure, cardiac or asthma medications, etc.). Short-term medications such as antibiotics do not need to be listed on this form. Long-term antibiotics such as antibiotics for urinary tract infections or sickle cell prophylaxis should be included.

PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigger medication administration.

Please be specific about what over-the-counter (OTC) medications you recommend, and include information for the parent and child care provider as to dosage, route, frequency, and possible side effects. Many child care providers may require separate permissions slips for prescription and OTC medications.

c. Limitations to physical activity - Please be as specific as possible and include dates of limitation as appropriate. Any limitation to field trips should be noted. Note any special considerations such as avoiding sun exposure or exposure to allergens. Potential severe reaction to insect stings should be noted. Special considerations such as back-only sleeping for infants should be noted.

d. Special Equipment – Enter if the child wears glasses, orthodontic devices, orthotics, or other special equipment. Children with complex equipment needs should have a care plan.

e. Allergies/Sensitivities - Children with life-threatening allergies should have a special care plan. Severe allergic reactions to animals or foods (wheezing etc.) should be noted. Pediatric asthma action plans can be obtained from The Pediatric Asthma Coalition of New Jersey at www.pacnj.org or by phone at 908-687-9340.

f. Special Diets - Any special diet and/or supplements that are medically indicated should be included. Exclusive breastfeeding should be noted.

g. Behavioral/Mental Health issues - Please note any significant behavioral problems or mental health diagnoses such as autism, breath holding, or ADHD.

h. Emergency Plans - May require a special care plan if interventions are complex. Be specific about signs and symptoms to watch for. Use simple language and avoid the use of complex medical terms.

4. Screening - This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public health personnel to track children's health. Please enter the date that the test was performed. Note if the test was abnormal or place an "N" if it was normal.
   - For lead screening state if the blood sample was capillary or venous and the value of the test performed.
   - For PPD enter millimeters of induration, and the date listed should be the date read. If a chest x-ray was done, record results.
   - Scoliosis screenings are done biennially in the public schools beginning at age 10.

This form may be used for clearance for sports or physical education. As such, please check the box above the signature line and make any appropriate notations in the Limitation to Physical Activities block.

5. Please sign and date the form with the date the form was completed (note the date of the exam, if different)
   - Print the health care provider's name.
   - Stamp with health care site's name, address and phone number.
**EARLY CHILDHOOD HEALTH HISTORY QUESTIONNAIRE**

**Student’s Name __________________________ Date of Birth __________________________**

**Parents/Guardian __________________________ Daytime Phone Number __________________________**

**Child’s Doctor __________________________ Cell/Emergency Number __________________________**

### Prenatal

- Were you sick during your pregnancy? Yes ____  No ____
  - If yes, please explain __________________________
  - Full term ____  Premature ____  Complications __________________________

- What type of delivery did you have? Normal ____  C-Section ____

### Neonatal

- How much did your baby weigh at birth? __________________________
- Was your baby sick in the first few days of life? Yes ____  No ____
  - If yes, please explain __________________________

### Developmental Milestones (age at which the child)

- Sat up _____  Crawled _____  Walked _____  Talked _____  Toilet Trained _____

### Health Problems

Has your child ever had any of the following?

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Age</th>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart disease</td>
<td></td>
<td></td>
<td></td>
<td>Seizure/Convulsion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fainting</td>
<td></td>
<td></td>
<td></td>
<td>Diabetes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney Disease</td>
<td></td>
<td></td>
<td></td>
<td>Ear Infections</td>
<td></td>
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</tr>
<tr>
<td>Sickle Cell</td>
<td></td>
<td></td>
<td></td>
<td>Lead Poisoning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing Problem</td>
<td></td>
<td></td>
<td></td>
<td>Learning Problem</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision Problem</td>
<td></td>
<td></td>
<td></td>
<td>Broken Bones</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery</td>
<td></td>
<td></td>
<td></td>
<td>Asthma</td>
<td></td>
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</tr>
</tbody>
</table>

Explain any “yes” answers and list any other health problems.

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**CONTINUED ON NEXT PAGE>>>>>>>>>>>>>**
Activity restrictions specified by MD (note required) ________________________________

Hospitalizations
Has your child ever been hospitalized for any reason? Yes _____ No _____
Reason for hospitalization ___________________ How many days? _____ Year _____
Reason for hospitalization ___________________ How many days? _____ Year _____

Asthma
Has your child ever had asthma? Yes _____ No _____
How often does your child have asthma attacks? _________________________________
What triggers your child’s asthma? _________________________________
Has your child used asthma medicine in the past 2 years? Yes _____ No _____
If yes, please indicate medicine used _________________________________

Allergies
To food? Yes _____ No _____
To medicine? Yes _____ No _____
If yes, please list things child is allergic to and indicate symptoms:
________________________________________________________________________

Anaphylaxis? Yes _____ No _____
EpiPen? Yes _____ No _____

Medications
Does your child take any prescription medicine at home? Yes _____ No _____
If yes, please list medicine(s) _________________________________

Will your child be taking prescription medicine at school? Yes _____ No _____
If yes, what medicine(s)? _________________________________

Parents/Guardian Signature: ___________________________ Date ____________

I GIVE PERMISSION TO SHARE THIS INFORMATION WITH STAFF MEMBERS INVOLVED IN MY CHILD’S CARE AND EDUCATION.

Parents/Guardian Signature: ___________________________ Date ____________

Reviewed by: ___________________________ Date ____________
Name: ___________________________ D.O.B.: ___________________________

Allergic to: ___________________________

Weight: ___________________________ lbs. Asthma: □ Yes (higher risk for a severe reaction) □ No

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

Extremely reactive to the following allergens: ___________________________

THEREFORE:

□ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

□ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR ANY OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Shortness of breath, wheezing, repetitive cough

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

THROAT
Tight or hoarse throat, trouble breathing or swallowing

MOUTH
Significant swelling of the tongue or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. INJECT EPINEPHRINE IMMEDIATELY.

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

MILD SYMPTOMS

NOSE
Itchy or runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea or discomfort

FOR MILD SYMPTOMS FROM MORE THAN ONE 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 Brand or Generic: ___________________________

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

Antihistamine Brand or Generic: ___________________________

Antihistamine Dose: ___________________________

Other (e.g., inhaler-bronchodilator if wheezing): ___________________________
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO
1. Remove Auvi-Q from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.

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

WHAT TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS
1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip. Grasp the auto-injector in your fist with the red tip pointing upward.
3. Press the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh. Press down hard and hold firmly against the thigh for approximately 10 seconds.
4. Remove and massage the area for 10 seconds. Call 911 and get emergency medical help right away.

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

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

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

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

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

<table>
<thead>
<tr>
<th>RESCUE SQUAD:</th>
<th>DOCTOR:</th>
<th>PARENT/GUARDIAN:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHONE:</td>
<td>PHONE:</td>
<td>PHONE:</td>
</tr>
</tbody>
</table>

OTHER EMERGENCY CONTACTS

<table>
<thead>
<tr>
<th>NAME/RELATIONSHIP:</th>
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FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020
**Asthma Treatment Plan – Student**

(Physician’s Orders)

**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.**

<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 a day</td>
</tr>
<tr>
<td>Alvesco® 80, 160</td>
<td>1, 2 puffs a day</td>
</tr>
<tr>
<td>Dulera® 100, 200</td>
<td>1, 2 puffs twice a day</td>
</tr>
<tr>
<td>Flovent® 44, 110, 220</td>
<td>2 puffs a day</td>
</tr>
<tr>
<td>Qu-var® 40, 80</td>
<td>1, 2 puffs twice a day</td>
</tr>
<tr>
<td>Symbicort® 80, 160</td>
<td>1, 2 puffs twice a day</td>
</tr>
<tr>
<td>Advair Diskus® 100, 250, 500</td>
<td>1 inhalation twice a day</td>
</tr>
<tr>
<td>Asmanex® Twisthaler® 110, 220</td>
<td>1, 2 inhalations once or twice a day</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, 2 inhalations once or twice a day</td>
</tr>
<tr>
<td>Pulmicort Resuples® (Budesonide) 0.25, 0.5, 1.0 mg</td>
<td>1 tablet daily</td>
</tr>
<tr>
<td>Singular® (Montelukast) 4, 5, 10 mg</td>
<td>1 tablet daily</td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>

Remember to rinse your mouth after taking inhaled medicine.

If exercise triggers your asthma, take __________ puffs __________ 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 __________

**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 __________

**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>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>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

**Permission to Self-administer Medication:**
- This student is capable and has been instructed in the proper method of self-administering the non-nebulized medications named above in accordance with NJ Law.
- This student is not approved to self-medicate.

**Physician's Orders**

**PHYSICIAN/APN/PA SIGNATURE:** ____________ **PHYSICIAN STAMP:** ____________

**PA FINE/GUARDIAN SIGNATURE:** ____________ **PA FINE/COMMITTEE SIGNATURE:** ____________

**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 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

The Pediatric/Adult Asthma Coalition of New Jersey is an organization that educates, assists, and empowers those affected by asthma. We provide support to individuals, families, and communities and advocate for policies that improve asthma care and decrease asthma-related disparities. Our goal is to break the cycle of asthma and create a healthier world for all. Please visit our website at www.pacnj.org for more information on how to join our mission. This publication is supported by a grant from the New Jersey Department of Health and Senior Services, with funds provided by the U.S. Centers for Disease Control and Prevention under Cooperative Agreement 5U60/CCU517684-8. As names are not legally responsible for the actions and do not necessarily represent the official views of the New Jersey Department of Health and Senior Services or the U.S. Centers for Disease Control and Prevention, although this document has been funded wholly or in part by the United States Environmental Protection Agency under Agreement CR825990. The American Lung Association in New Jersey is a 501(c)(3) non-profit organization. Information in this publication is not intended to diagnose health conditions or take the place of medical advice. For any medical condition, see medical advice from your health care provider first.