THE GROWING TREE
LEARNING CENTER
Discover, Learn, and Have Fun

MEDICAL PACKET

MEDICAL DOCUMENTS MUST BE COMPLETED BY A PHYSICIAN ***SIGNED AND STAMPED*** AND PARENT/GUARDIAN BEFORE REGISTRATION.

- **Immunizations** must be up to date with this packet.
- If you are claiming **"Religious Exemption",** you must provide a Letter with this packet along with your Signature.
- If your child is going to be receiving Services at our school, you must provide a **"Placement Letter**" from your case worker.
- The **Health Questionnaire** must be filled out by the Parent.
- The **Universal, Asthma, Allergy, and Seizer** forms must be filled out by the doctor, signed, and stamped

(IF YOUR CHILD NEEDS MEDICATION WITH ANY OF THESE FORMS, YOU MUST PROVIDE MEDICATION **BEFORE** THE CHILD'S FIRST **DAY OF SCHOOL**. MEDICATION HAS TO BE NEW-UNUSED, NOT EXPIRED, AND EXACT TO THE FORM THAT WAS PROVIDED BY THE DR.)

THE GROWING TREE LEARNING CENTER

27 Fisk Street, Jersey City, NJ 07305
TEL: 201-860-0044 / FAX: 201-860-0088

INFLUENZA VACCINE DUE DECEMBER 18, 2025

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. 2025.

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

CHILDS NAME: _____

PARENT/ LEGAL GUARDIANS NAME: _____

PARENTS/ LEGAL GUARDIANS SIGNATURE: _____

DATE: _____

THE JERSEY CITY PUBLIC SCHOOLS
346 CLAREMONT AVENUE
JERSEY CITY, NJ 07305
PH (201) 915-6222
FAX (201) 332-7494

SCHOOL: _____ PRINCIPAL: _____

HEALTH HISTORY

Birth History: Full Term_____ Premature_____ Birth Weight_____

Delivery Normal_____ Caesarean Section_____

Place of Birth: _____

Complications:

_____

_____

_____

Has child had or has any of the following? Please indicate age of child when condition occurred:

Chicken Pox_____	Ear Infection_____	Vision Problems_____
Measles _____	Diabetes_____	Hearing Problems_____
Scarlet Fever_____	Anemia_____	Speech Problems_____
Convulsions_____	Heart Problems_____	Difficulty Learning _____
Allergies_____	Asthma_____	Surgery _____
Tuberculosis_____	Lead Poisoning_____	Concussion_____
Broken Bones_____	Rheumatic Fever_____	Other_____
		Other_____

Has child been hospitalized overnight since birth? Yes_____ No_____
If yes, please answer the following in the comment section:
When? Where? How long? Why?
Comments:

_____

_____

_____

Will this child be able to participate in the following classes?
Physical Education: Yes_____ No_____ Why?_____

Does child currently take medication? Yes_____ No_____ Name of medication_____

Will this child be taking medication during school hours? Yes_____ No_____

Pediatrician, Family Doctor or Clinic:

Name_____ Address_____ Phone # _____

Date:_____ Gender:_____ School:_____ Grade_____

Name:_____ DOB:_____

Address:_____ Apt#_____ Phone:_____

Mother's Name:_____ Phone# _____

Father's Name:_____ Phone# _____

Guardian's Name:_____ Phone# _____

Name of Relative attending this school:

Name	Relationship	Grade	Room

Person to call if Parent/Guardian cannot be reached:

Name_____ Phone #_____ Relationship_____

Name_____ Phone #_____ Relationship_____

We are concerned about the welfare of your child. It is recommended that with the Parent's/Guardian's permission, significant health information be shared with those involved in teaching your child.

_____ I do not want this information shared.

_____ I give permission for the school nurse to share this information with those involved in teaching my child.

_____

Parent/Guardian Signature Date

FOR CHILD CARE/PRESCHOOL DIRECTORS AND PARENTS: IMMUNIZATION REQUIREMENTS

NJ Department of Health (NJDOH)
Vaccine Preventable Disease Program

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/cd/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.

At this age the child should have received the following vaccines:	**2 months**	**4 months**	**6 months**	**12 months**	**15 months**	**18 months**	**19 months**	**20-59 months**
Diphtheria, tetanus & acellular pertussis (DTaP)	Dose #1	Dose #2	Dose #3			Dose #4		
Inactivated Poliovirus (Polio)	Dose #1	Dose #2				Dose#3		
Haemophilus influenzae type b (Hib)	Dose #1	Dose #2		1-4 doses† (see footnote)	.	At least 1 dose given on or after the first birthday		
Pneumococcal conjugate (PCV 13)	Dose #1	Dose #2		1-4 doses† (see footnote)	At least 1 dose given on or after the first birthday			
Measles, mumps, rubella (MMR)					Dose #1‡			
Varicella (VAR)							Dose #1 §	
Influenza (IIV; LAIV)			One dose due each year‖					

***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.

†***Haemophilus influenzae* type b (Hib) and pneumococcal (PCV)** vaccines are special cases. If children started late with these vaccines they 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, children 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, children may enter preschool/child care without a documented dose of varicella. Children who previously had chickenpox do not need to receive the varicella vaccine as long as a parent/guardian 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. Children 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. Children 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.

This document is meant to be a quick resource. For more information "NJ Immunization Requirements Frequently Asked Questions", please visit https://nj.gov/health/cd/imm_requirements/.

Reviewed: 12/2021

***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.**

APPENDIX H

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: *American Academy of Pediatrics, New Jersey Chapter*
New Jersey Academy of Family Physicians
New Jersey Department of Health

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	Comments
Medications/Treatments • List medications/treatments:	☐ None ☐ Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☐ None ☐ Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐ None ☐ Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☐ None ☐ Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☐ None ☐ Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☐ None ☐ Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: ☐ Capillary ☐ Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

☐ ***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.***

Name of Health Care Provider (Print)	Health Care Provider Stamp:
Signature/Date	

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 heath 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.

Asthma Treatment Plan – Student

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

PACNJ Pediatric/Adult Asthma Coalition

Sponsored by AMERICAN LUNG ASSOCIATION. IN NEW JERSEY

NJ Health New Jersey Department of Health

(Please Print)

Name	Date of Birth	Effective Date
Doctor Phone	Parent/Guardian (if applicable) Phone	Emergency Contact 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	HOW MUCH to take and HOW OFTEN to take it
☐ Advair® HFA ☐ 45, ☐ 115, ☐ 230	2 puffs twice a day
☐ Aerospan™	☐ 1, ☐ 2 puffs twice a day
☐ Alvesco® ☐ 80, ☐ 160	☐ 1, ☐ 2 puffs twice a day
☐ Dulera® ☐ 100, ☐ 200	2 puffs twice a day
☐ Flovent® ☐ 44, ☐ 110, ☐ 220	2 puffs twice a day
☐ Qvar® ☐ 40, ☐ 80	☐ 1, ☐ 2 puffs twice a day
☐ Symbicort® ☐ 80, ☐ 160	☐ 1, ☐ 2 puffs twice a day
☐ Advair Diskus® ☐ 100, ☐ 250, ☐ 500	1 inhalation twice a day
☐ Asmanex® Twisthaler® ☐ 110, ☐ 220	☐ 1, ☐ 2 inhalations ☐ once or ☐ twice a day
☐ Flovent® Diskus® ☐ 50 ☐ 100 ☐ 250	1 inhalation twice a day
☐ Pulmicort Flexhaler® ☐ 90, ☐ 180	☐ 1, ☐ 2 inhalations ☐ once or ☐ twice a day
☐ Pulmicort Respules® (Budesonide) ☐ 0.25, ☐ 0.5, ☐ 1.0	1 unit nebulized ☐ once or ☐ twice a day
☐ Singulair® (Montelukast) ☐ 4, ☐ 5, ☐ 10 mg	1 tablet daily
☐ Other	
☐ None	

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	HOW MUCH to take and HOW OFTEN to take it
☐ 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	HOW MUCH to take and HOW OFTEN to take it
☐ 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	

Triggers

Check all items that trigger patient's asthma:

- ❑ Colds/flu
- ❑ Exercise
- ❑ Allergens
  - ○ Dust Mites, dust, stuffed animals, carpet
  - ○ Pollen - trees, grass, weeds
  - ○ Mold
  - ○ Pets - animal dander
  - ○ Pests - rodents, cockroaches
- ❑ Odors (Irritants)
  - ○ Cigarette smoke & second hand smoke
  - ○ Perfumes, cleaning products, scented products
  - ○ Smoke from burning wood, inside or outside
- ❑ Weather
  - ○ Sudden temperature change
  - ○ Extreme weather - hot and cold
  - ○ Ozone alert days
- ❑ Foods:
  - ○ _____
  - ○ _____
  - ○ _____
- ❑ Other:
  - ○ _____
  - ○ _____
  - ○ _____

This asthma treatment plan is meant to assist, not replace, the clinical decision-making required to meet individual patient needs.

REVISED MAY 2017

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_____ DATE_____

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 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

PACNJ Pediatric/Adult Asthma Coalition

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Sponsored by AMERICAN LUNG ASSOCIATION® IN NEW JERSEY

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

FARE Food Allergy Research & Education

PLACE PICTURE HERE

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.

☐ **Special Situation/Circumstance - If this box is checked, the child has an extremely severe allergy to the following food(s) _____.**

Even if the child has MILD symptoms after eating (ingesting) this food(s), Give Epinephrine immediately.

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 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 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 BODY SYSTEM**, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM A **SINGLE BODY SYSTEM** (E.G. SKIN, GI, ETC.), 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): _____

_____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE

HEALTHCARE PROVIDER AUTHORIZATION SIGNATURE DATE

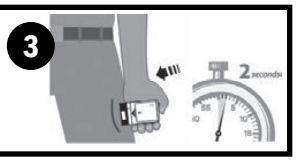
Form provided courtesy of **Food Allergy Research & Education** (FARE - FoodAllergy.org) - January 2023

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

FARE
Food Allergy Research & Education

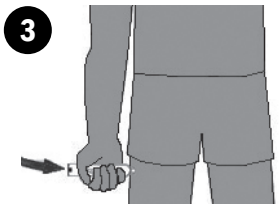
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

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.



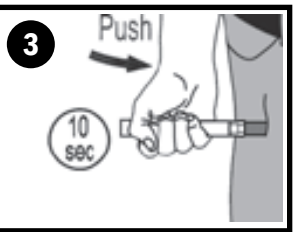
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION

1. (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN
2. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
3. 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.
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.



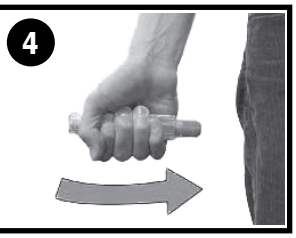
HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

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 downward.
3. Put 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-outer 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.):

Epinephrine first, then **call 911**. Monitor the patient and call their emergency contacts right away.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

Form provided courtesy of **Food Allergy Research & Education** (FARE - FoodAllergy.org) - January 2023

SEIZURE ACTION PLAN (SAP)

EPILEPSY FOUNDATION | END EPILEPSY

Name: _____ Birth Date: _____

Address: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Emergency Contact/Relationship _____ Phone: _____

Seizure Information

Seizure Type	How Long It Lasts	How Often	What Happens

Protocol for seizure during school (check all that apply) ☑

- ☐ First aid – **Stay. Safe. Side.**
- ☐ Give rescue therapy according to SAP
- ☐ Notify parent/emergency contact
- ☐ Contact school nurse at _____
- ☐ Call 911 for transport to _____
- ☐ Other _____

First aid for any seizure

- ☐ **STAY** calm, keep calm, **begin timing seizure**
- ☐ Keep me **SAFE** – remove harmful objects, don't restrain, protect head
- ☐ **SIDE** – turn on side if not awake, keep airway clear, don't put objects in mouth
- ☐ **STAY** until recovered from seizure
- ☐ Swipe magnet for VNS
- ☐ Write down what happens _____
- ☐ Other _____

When to call 911

- ☐ Seizure with loss of consciousness longer than 5 minutes, not responding to rescue med if available
- ☐ Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med if available
- ☐ Difficulty breathing after seizure
- ☐ Serious injury occurs or suspected, seizure in water

When to call your provider first

- ☐ Change in seizure type, number or pattern
- ☐ Person does not return to usual behavior (i.e., confused for a long period)
- ☐ First time seizure that stops on its' own
- ☐ Other medical problems or pregnancy need to be checked

When **rescue therapy** may be needed:

WHEN AND WHAT TO DO

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

Care after seizure

What type of help is needed? (describe) _____

When is student able to resume usual activity? _____

Special instructions

First Responders: _____

_____

Emergency Department: _____

_____

Daily seizure medicine

Medicine Name	Total Daily Amount	Amount of Tab/Liquid	How Taken (time of each dose and how much)

Other information

Triggers: _____

Important Medical History _____

Allergies _____

Epilepsy Surgery (type, date, side effects) _____

Device: ☐ VNS ☐ RNS ☐ DBS Date Implanted _____

Diet Therapy ☐ Ketogenic ☐ Low Glycemic ☐ Modified Atkins ☐ Other (describe) _____

Special Instructions: _____

_____

Health care contacts

Epilepsy Provider: _____ Phone: _____

Primary Care: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

Pharmacy: _____ Phone: _____

My signature _____ Date _____

Provider signature _____ Date _____

Epilepsy.com

Revised 01/2020 130SRP/PAB1216

EPILEPSY FOUNDATION | END EPILEPSY