KIPP COOPER NORCROSS

Health Packet

- **New Students:** This health packet must be completed as part of your enrollment
- **Returning Students:** Must complete the parent section as outlined below. In addition, it is recommended that all students get an updated physical yearly.
- Please refer to the following table for completion

Parents *Must complete:*	**Pediatrician** *Must complete:*
➢ Page 2 – Section 1 ➢ Page 2 – Section 2 (if indicated)	➢ Physical Examination Form
➢ Page 3 – Initial all sections	➢ Attach updated Immunizations
➢ Sign and date all indicated areas	➢ Chronic condition Plans (if indicated)

- The completed packet can be submitted to the nurse in the following ways:

Hand deliver to the school	**Email your School Nurse**	**Upload to the Link**
KIPP Lanning Square Primary 525 Clinton Street, Camden, NJ, 08103	Nurse Tasha Nurse Kabrina CamdenNurses@kippnj.org	https://tinyurl.com/3f9vqlpj
KIPP Lanning Square Middle 525 Clinton Street, Camden, NJ, 08103		https://tinyurl.com/3f9vqlpj
KIPP Sumner Elementary 1600 S. 8th Street, Camden, NJ, 08104	Nurse Colleen CamdenNurses@kippnj.org	https://tinyurl.com/3f9vqlpj
KIPP Hatch Middle 1600 S. 8th Street, Camden, NJ, 08104		https://tinyurl.com/3f9vqlpj
KIPP High School 740 Chestnut Street, Camden, NJ, 08103	Nurse Kim CamdenNurses@kippnj.org	https://tinyurl.com/3f9vqlpj

You can also scan this QR code that will take you directly to the above link where you can upload all your health paperwork and also let the nurse know if your student(s) have any health concerns that we should be made aware of.

KIPP COOPER NORCROSS

Paquete de Salud

- **Estudiantes nuevos:** Este paquete de salud debe completarse como parte de su inscripción.
- **Estudiantes que regresan:** Deben completer la sección para padres como se describe a continuación. Además, se recomienda que todos los estudiantes obtengan un examen físico actualizado anualmente.
- Consulte la siguiente table para completer

Padres *Debe completer:*	**Pediatra** *Debe completer:*
• Página 2 – Sección 1 • Página 2 – Sección 2 (si se indica)	• Formulario de examen físico
• Página 3 – Escriba sus iniciales en todos las secciones	• Adjunte las vacunas actualizadas
• Firme y feche todos las áreas indicadas	• Planes de condiciones crónicas (si se indica)

- El paquete complete se puede enviar a la enfermera de las siguientes maneras:

Entregar en Mano a la Escuela	**Envie un correo electronico a su enfermera de la Escuela**	**Subir al enlace**
KIPP Lanning Square Primary 525 Clinton Street, Camden, NJ, 08103	Enfermera Tasha Enfermera Kabrina CamdenNurses@kippnj.org	https://tinyurl.com/3f9vqlpj
KIPP Lanning Square Middle 525 Clinton Street, Camden, NJ, 08103		https://tinyurl.com/3f9vqlpj
KIPP Sumner Elementary 1600 S. 8th Street, Camden, NJ, 08104	Enfermera Colleen CamdenNurses@kippnj.org	https://tinyurl.com/3f9vqlpj
KIPP Hatch Middle 1600 S. 8th Street, Camden, NJ, 08104		https://tinyurl.com/3f9vqlpj
KIPP High School 740 Chestnut Street, Camden, NJ, 08103	Enfermera Kim CamdenNurses@kippnj.org	https://tinyurl.com/3f9vqlpj

También puede escanear este Código QR que lo llevará directamente al enlace anterior donde puede cargar todos sus documentos de salud y tanbién informarle a la enfermera sis u(s) estudiantes(s) tiene(n) algún problema de salud que debamos conocer.

SCHOOL	GRADE	STUDENT NAME

NJ STATE SPORTS PHYSICAL ENCLOSED*

KIPP NJ Physical Forms

The forms in this packet must be completed by your child's doctor & the parent/guardian.

This physical packet is due within 30 days:

- Returning students: 30 days from the first day of school
- New students: 30 days from registration

When submitting this form, we STRONGLY recommend that you submit it directly to the nurse's office to ensure it does not get misplaced!

Dear Parent/Guardian,

We at KIPP NJ pride ourselves on delivering the best health care possible to each and every one of our scholars. It is our mission and joy in life to make sure that when your child walks into his/her school building, they are not only receiving a quality education, but they are safe, happy, and healthy as well!
In order to achieve this goal of safe, happy, healthy scholars we need your help!

All new incoming scholars are required to submit the KIPP NJ Physical form (which must have been completed less than 12 months ago) as well as an up to date immunization record.

If you are having difficulty completing the above stated requirements, please note the following resources for your convenience:

Immunization Resource(s):
Camden County Immunization Program 600 Market St. Camden, NJ 08102 (FREE Immunizations for Camden residents with no insurance) 856.225.5128
Physical and Immunizations Resource: Cooper Clinic at KIPP Cooper Norcross Academy 525 Clinton Street, Camden, NJ, 080103 856.536.1511

If you have any questions or concerns about any of the documents that we require, please feel free to reach out to us. We would be more than happy to assist you in finding any resources or health services for your child!

Love,
The School Nurses

KIPP Lanning Square,	**856.966.9600**	**EXT**	**3**
KIPP High School,	**856.359.7046**	**EXT**	**2**
KIPP Sumner Elem, Hatch Middle	**856.263.6235**		

KIPP NJ STUDENT HEALTH INFORMATION & RELEASE

Section 1: GENERAL INFORMATION

Student's Name _____ Date of Birth _____

Parent's Name _____ Parent's Phone Number _____

May the School Nurse contact the student's physician? ☐ Yes ☐ No

May health information be released to the School Nurse? ☐ Yes ☐ No

Does the student have health insurance? ☐ Yes ☐ No

Section 2: ALLERGIES

FOOD ALLERGIES

Please list any allergies and/or sensitivities

examples: peanut butter, milk, eggs, shellfish, etc.

_____

_____

MEDICINES

Please list any allergies and/or sensitivities

examples: penicillin, insulin, etc.

_____

_____

BEE STINGS

Is the student allergic to bee stings?

☐ Yes ☐ No

POLLENS

Please list any allergies and/or sensitivities

examples: ragweed, mold, etc.

_____

_____

Section 3: OVER-THE-COUNTER MEDICATION & EMERGENCY TREATMENT

I hereby give permission to KIPP NJ to administer medications to the above named student, as designated in the *KIPP NJ Medical Standing Orders* issued by the school physician.

I agree that KIPP NJ and its employees are not to be held liable for giving medicine in accordance with this Authorization. I agree to hold harmless and indemnify KIPP NJ and all of its employees against any and all claims, damages, expenses, attorney's fees, suits, cause or causes of action which may be brought against the network or its employees in connection with giving such medicine. This Authorization shall be effective unless revoked by me in writing. intend to be legally bound by this Authorization.

In the event a parent/guardian cannot be reached, I hereby give permission to KIPP NJ to obtain emergency medical treatment for the above named child, including X-Rays, and to release information pertaining to my child's health record, diagnosis, condition or health history, including subsequent diagnosis which could supplement this form. This information may be released by a properly authorized representative of the school responsible for my child during periods of time when the school nurse is unavailable or when the student is away from the school building (i.e. during field trips).

PARENT/GUARDIAN SIGNATURE

_____ _____

Parent/Guardian Signature Date

KIPP NJ MEDICATION POLICY

PRESCRIPTION MEDICATIONS

All medications are to be administered by the school nurse. In the absence of trained medical personnel a sub nurse should be called to administer medication to students. The school nurse will be the one to delegate, educate, and train non-medical staff on how to give **epinephrine only** for cases of severe allergic reactions.

In order for prescription medications to be given in school a written *medication administration form* must be completed by the physician that provides the name of the drug, dose, time it is to be taken, and the diagnosis or reason the medication is needed. The use of the *Asthma Action Plan* is the form to be completed for all students who are asthmatic. These forms will need to be completed upon each new school year.

All prescription medications brought to school should be in their original container and appropriately labeled by the pharmacist. Parents must bring in and pick up all medications. No medications will be released to students unless given written permission to do so by the parent. All medications not picked up by the last day of school will be discarded.

Parent/guardian Initial: _____

OVER THE COUNTER MEDICATIONS

The only over the counter medications that will be provided by the school and administered in school will be the ones outlined in the *Standing Medication Orders* as indicated and for the purpose noted by the KIPP NJ School Physician. Medications for these conditions will only be given if an over the counter medication form is signed by the parent or guardian and is on file in the health office. Over the counter medications are not to be brought in to school unless accompanied by a written note from their doctor and must be signed by parent/guardian.

No student is permitted to carry medication with them of any kind during the school day unless cleared by a doctor to self administer. In this case the student should still have a medication administration form on file and if possible back up medication in the health office. Physicians must also document that it is okay for student to carry own medication. Please note this allowance is not applicable for elementary aged students.

Parent/guardian Initial: _____

FIELD TRIPS

Please be advised that the school nurse will not be accompanying the staff and students on field trips. Parents or guardians are responsible to ensure that their child receives their respective medications during the trip and are properly educated on the use of any prescribed medications or treatments that may be needed during this trip. Please note, teachers are not able to administer medications during field trips.

Parent/guardian Initial: _____

HERBAL MEDICATIONS AND VITAMINS

These types of medications will not be given in school without written documentation from the physician and signed by the parents.

Parent/guardian Initial: _____

ROUTINE FIRST AID

The district doctor will provide standing orders on a yearly basis for routine first-aid treatments and emergency medications as well as over-the-counter routine items including but not limited to eyewash, Bacitracin, Caladryl, Vitamin A & D Ointment, Sting wipes, Bactine, Burn gel, Band-Aid Antiseptic wash which will be used for routine first aid needs.

Parent/guardian Initial: _____

OTHER GUIDELINES

It will be the parent's responsibility to supply the school with all prescribed medications and medical devices such as nebulizer tubing and mask, insulin syringes and needles. The school will provide the nebulizer.

All given medications should be documented on the daily medication log whether emergency or routine. If a student has an IEP medications given should also be logged into SEMI. Any errors in the administration of medications should be reported to the district doctor so that corrective measures can be taken immediately.

_____ _____

Parent/Guardian Signature Date

ATTENTION PARENT/GUARDIAN: The preparticipation physical examination (page 3) must be completed by a health care provider who has completed the Student-Athlete Cardiac Assessment Professional Development Module.

PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

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

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

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

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

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

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

_____

_____

_____

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

HE0503 9-2681/0410

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

PREPARTICIPATION PHYSICAL EVALUATION

THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

1. Type of disability
2. Date of disability
3. Classification (if available)
4. Cause of disability (birth, disease, accident/trauma, other)
5. List the sports you are interested in playing

	Yes	No
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

Please indicate if you have ever had any of the following.

	Yes	No
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

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

NOTE: The preparticiaption physical examination must be conducted by a health care provider who 1) is a licensed physician, advanced practice nurse, or physician assistant; and 2) completed the Student-Athlete Cardiac Assessment Professional Development Module.

PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

1. **Consider additional questions on more sensitive issues**
   - **Do you feel stressed out or under a lot of pressure?**
   - **Do you ever feel sad, hopeless, depressed, or anxious?**
   - **Do you feel safe at your home or residence?**
   - **Have you ever tried cigarettes, chewing tobacco, snuff, or dip?**
   - **During the past 30 days, did you use chewing tobacco, snuff, or dip?**
   - **Do you drink alcohol or use any other drugs?**
   - **Have you ever taken anabolic steroids or used any other performance supplement?**
   - **Have you ever taken any supplements to help you gain or lose weight or improve your performance?**
   - **Do you wear a seat belt, use a helmet, and use condoms?**
2. **Consider reviewing questions on cardiovascular symptoms (questions 5–14).**

EXAMINATION		
Height Weight ☐ Male ☐ Female		
BP / (/) Pulse Vision R 20/ L 20/ Corrected ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart [a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic [c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason_____Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) (print/type)_____Date of exam _____

Address_____Phone _____

Signature of physician, APN, PA _____

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

PREPARTICIPATION PHYSICAL EVALUATION
CLEARANCE FORM

Name _____ Sex ☐ M ☐ F Age _____ Date of birth _____

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason _____ Recommendations _____

EMERGENCY INFORMATION

Allergies _____

Other information _____

HCP OFFICE STAMP

SCHOOL PHYSICIAN:

Reviewed on _____
(Date)

Approved _____ Not Approved _____

Signature: _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) _____ Date _____

Address _____ Phone _____

Signature of physician, APN, PA _____

Completed Cardiac Assessment Professional Development Module

Date _____ Signature _____

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

Physical Evaluation
Immunization Clearance

Doctor/Practitioner please complete this page
Note: You may attach an up to date immunization record in place of filling out this page

Name_____ Sex ☐M ☐F Age_____ Date of birth _____

VACCINE TYPE	1st Dose Mo/Day/Yr	2nd Dose Mo/Day/Yr	3rd Dose Mo/Day/Yr	4th Dose Mo/Day/Yr	5th Dose Mo/Day/Yr	LEAD SCREENING	
						Test Date	Result
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination (If Td or DT, indicate in corner box)							
Tdap							
POLIO – INACTIVATED POLIO VACCINE (IPV) If oral vaccine, indicate (OPV) in corner box							
MEASLES, MUMPS, RUBELLA (MMR)							
HAEMOPHILUS B (HIB)**							
HEPATITIS B							
VARICELLA							
PNEUMOCOCCAL CONJUGATE **							
MENINGOCOCCAL							
HEPATITIS A ***							
HPV (HUMAN PAPILLOMAVIRUS) ***							
OTHER							

Document below single antigen vaccine receipt, serology titers, or varicella disease history

Hepatitis B	Date:	Titer:
Varicella	Date:	Titer:
Measles	Date:	Titer:
Mumps	Date:	Titer:
Rubella	Date:	Titer:

▪ Provisional admission attached–Date Granted:_____ ▪ Medical exemption attached ■ Religious exemption attached

******Please Note that KIPP NJ requires that all incoming 6th grade students recieve the first dose of the Meningococcol & Tdap vaccines prior to the start of 6th grade or no later than the 11th birthday of the child.***

Has this child recieved the first dose of the MCV4 Meningococcol Vaccine? ☐ Yes ☐ No

If Meningococcol vaccine was not given due to age please specify when patient is scheduled to return for vaccination:

Appointment Date: _____

Has this child recieved the first dose of the Tdap Vaccine? ☐ Yes ☐ No

If Tdap vaccine was not given due to age please specify when patient is scheduled to return for vaccination:

Appointment Date: _____

Has this child recieved a PPD/Mantoux during this doctors visit? ☐ Yes ☐ No

Date Placed: _____ Location: _____

Date Read: _____ Results (mm):

Read by: _____

Practitioner Signature: _____

Health Office Use only:

Based on his/her current immunization status, is this child cleared to start school? ☐ Yes ☐ No

If not, which immunization(s) or document(s) are missing? : _____

_____

School Nurse Signature: _____ Date: _____

Please have your child's doctor complete the following attached forms if your child has:

1. **Asthma**
2. **Food Allergies**
3. **Seizure Disorder**
4. **Requires any kind of medication during school hours**

A doctor must sign all forms that apply.

Asthma Treatment Plan – Student

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

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

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
D Advair® HFA D 45, D 115, D 230	2 puffs twice a day
D Aerospan™	D 1, D 2 puffs twice a day
D Alvesco® D 80, D 160	D 1, D 2 puffs twice a day
D Dulera® D 100, D 200	2 puffs twice a day
D Flovent® D 44, D 110, D 220	2 puffs twice a day
D Qvar® D 40, D 80	D 1, D 2 puffs twice a day
D Symbicort® D 80, D 160	D 1, D 2 puffs twice a day
D Advair Diskus® D 100, D 250, D 500	1 inhalation twice a day
D Asmanex® Twisthaler® D 110, D 220	D 1, D 2 inhalations D once or D twice a day
D Flovent® Diskus® D 50 D 100 D 250	1 inhalation twice a day
D Pulmicort Flexhaler® D 90, D 180	D 1, D 2 inhalations D once or D twice a day
D Pulmicort Respules® (Budesonide) D 0.25, D 0.5, D 1.0	1 unit nebulized D once or D twice a day
D Singulair® (Montelukast) D 4, D 5, D 10 mg	1 tablet daily
D Other	
D None	

Remember to rinse your mouth after taking inhaled medicine.

If exercise triggers your asthma, take m puff(s) m 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
D Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	2 puffs every 4 hours as needed
D Xopenex®	2 puffs every 4 hours as needed
D Albuterol D 1.25, D 2.5 mg	1 unit nebulized every 4 hours as needed
D Duoneb®	1 unit nebulized every 4 hours as needed
D Xopenex® (Levalbuterol) D 0.31, D 0.63, D 1.25 mg	1 unit nebulized every 4 hours as needed
D Combivent Respimat®	1 inhalation 4 times a day
D Increase the dose of, or add:	
D 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
D Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	4 puffs every 20 minutes
D Xopenex®	4 puffs every 20 minutes
D Albuterol D 1.25, D 2.5 mg	1 unit nebulized every 20 minutes
D Duoneb®	1 unit nebulized every 20 minutes
D Xopenex® (Levalbuterol) D 0.31, D 0.63, D 1.25 mg	1 unit nebulized every 20 minutes
D Combivent Respimat®	1 inhalation 4 times a day
D 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.

The Pediatric/Adult Asthma Coalition of New Jersey, sponsored by the American Lung Association in New Jersey. This publication was 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 5U59EH000481-5. Its contents are solely the responsibility of the authors 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 XA82968012 to the American Lung Association in New Jersey, it has not gone through the Agency's publications review process and therefore, may not necessarily reflect the views of the Agency and no official endorsement should be inferred. Information in this publication is not intended to diagnose health problems or take the place of medical advice. For asthma or any medical condition, seek medical advice from your child's or your health care professional.

Permission to Self-administer Medication:
D 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.
D This student is not approved to self-medicate.

PHYSICIAN/APN/PA SIGNATURE _____ DATE _____
Physician's Orders

PARENT/GUARDIAN SIGNATURE _____

PHYSICIAN STAMP

REVISED AUGUST 2014

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

D 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.

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

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AMERICAN LUNG ASSOCIATION® IN NEW JERSEY

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name:_____ D.O.B.: _____

Allergy to: _____

Weight:_____lbs. Asthma: **[ ] Yes (higher risk for a severe reaction) [ ] No**

PLACE PICTURE HERE

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

Extremely reactive to the following foods: _____

THEREFORE:

[ ] If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

[ ] If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Short of breath, wheezing, repetitive cough

HEART
Pale, blue, faint, weak pulse, dizzy

THROAT
Tight, hoarse, trouble breathing/ swallowing

MOUTH
Significant swelling of the tongue and/or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

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

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell them the child is having anaphylaxis and may need epinephrine when they arrive.

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

MILD SYMPTOMS

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/ discomfort

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

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

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

MEDICATIONS/DOSES

Epinephrine Brand: _____

Epinephrine Dose: [ ] 0.15 mg IM [ ] 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

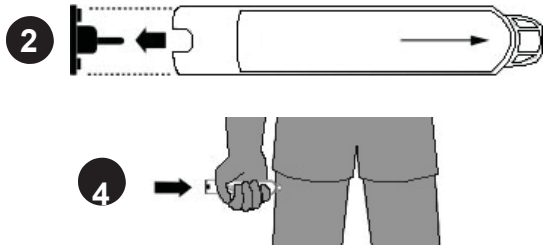
PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

FARE
Food Allergy Research & Education

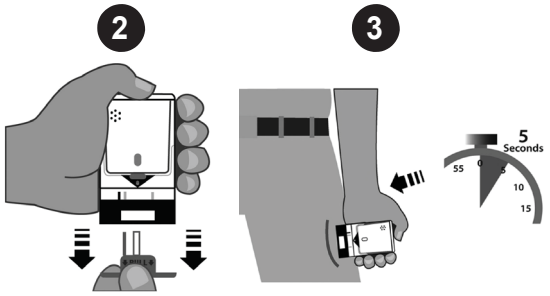
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

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.

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 get worse quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 5/2014

KIPP COOPER NORCROSS

Youth Seizure Action Plan

CONTACT INFORMATION:

Student's Name:_____ School Year:_____

School:_____ Grade:_____ Classroom:_____

Parent/Guardian Name:_____ Tel. (H):_____ (W):_____ (C):_____

Other Emergency Contact:_____ Tel. (H):_____ (W):_____ (C):_____

Child's Neurologist:_____ Tel:_____ Location:_____

Child's Primary Care Dr.:_____ Tel:_____ Location:_____

Significant medical history or conditions:

SEIZURE INFORMATION:

Seizure Type	*Length*	*Frequency*	*Description*

Seizure triggers or warning signs: _____

Response after a seizure: _____

_____

TREATMENT PROTOCOL: (include daily and emergency medications)

Medication	*Emergency Med?*	*Dosage & Time of Day Given*	*Route of Administration*	*Common Side Effects & Special Instructions*
	☐			
	☐			
	☐			

Does child have a **Vagus Nerve Stimulator (VNS)**? YES NO

If YES, describe magnet use_____

BASIC FIRST AID, CARE & COMFORT:

Please describe basic first aid procedures: _____

_____

Does person need to leave the room/area after a seizure? YES NO

If YES, describe process for returning: _____

_____

Basic seizure first aid:

- Stay calm & track time
- Keep person safe
- Do not restrain
- Do not put anything in mouth
- Stay with person until fully conscious
- Record seizure in log

For tonic-clonic (grand mal) seizure:

- Protect head
- Keep airway open/watch breathing
- Turn person on side

KIPP COOPER NORCROSS

Youth Seizure Action Plan

EMERGENCY RESPONSE:

A "seizure emergency" for this person is defined as: _____

_____

A seizure is considered an emergency when:
- A convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- There are repeated seizures without regaining consciousness
- It's a first-time seizure
- The person is injured or has diabetes
- The person has breathing difficulties
- The seizure is in water

Seizure Emergency Protocol: *(Check all that apply and clarify below)*

- ☐ **Call 911 for transport to** _____
- ☐ Notify parent or emergency contact
- ☐ Notify doctor
- ☐ Administer emergency medications as indicated below
- ☐ Other _____

SEIZURE INFORMATION:

1. When was your child diagnosed with epilepsy? _____
2. How often does your child have a seizure? _____
3. Has there been any recent change in your child's seizure patterns? YES NO
   If YES, please explain: _____
4. How do other illnesses affect your child's seizure control? _____
5. What should be done when your child misses a dose? _____
   (*Refer to physician care plan)*

SPECIAL CONSIDERATIONS & PRECAUTIONS:

Check any special considerations related to your child's epilepsy while at school. *(Check appropriate boxes and describe the impact of your child's seizures or treatment regimen)*

- ❑ General health:
- ❑ Phvsical education (gym)/sports:

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- ❑ Other: _____

GENERAL COMMUNICATION ISSUES:

What is the best way for us to communicate about your child's seizure(s)?: _____

Does school personnel have permission to contact your child's physician? YES NO

Can this information be shared with classroom teacher(s) and other appropriate school personnel? YES NO

Parent Signature: _____ Date: _____ Dates Updated _____, _____

Physician Signature: _____ Date: _____

Once this Seizure Action Plan has been filled out, take a copy for the school nurse to keep.

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Medication Administration Form

Student	**Parent**
School Year	**Legal Guardian**
School	**Home Phone**
Teacher	**Work Phone**
Grade	**Cell Phone**

TO BE COMPLETED BY THE PRESCRIBING HEALTHCARE PROVIDER. USE A SEPARATE FORM FOR EACH MEDICATION

Name of Medication	**Mg/mcg/ml/tsp**	**Take___tablet(s) Take___tsp**	**Total mg per dose**	**Time to take daily or as needed**

Reason for Medication: ADHD *Headache/Migraine* *Pain* *Other*

Side Effects/Precautions: _____

Start Date: / / Stop Date: / /

Note: The School Nurse will keep and give this medication for this student unless otherwise noted below.

This student is capable of keeping/taking this medication on his/her own: Yes No

Note: All controlled, stimulant and/or narcotic medication must be given and supervised by the nurse for all students at all grade levels.

Healthcare Provider Signature_____ **Date** _____

Healthcare Provider name (Print) _____ **Phone** _____

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN

Please Note: All medication must be in a properly labeled pharmacy container.

I hereby give my permission for my child (named above) to receive this (stated) medication at school. I assume full responsibility and will inform school staff of any medication changes or health status. I hereby release KIPP NJ, their agents, and employees from any and all liability that may occur as a result of any medication administration.

I will provide a new medication form each school year and each time the dose/medication changes.

I agree to furnish medication in an original, properly labeled pharmacy container.

I will pick-up unused/discontinued medication as needed during (or by end of) the school year.

Parent/Legal guardian Signature_____ **Date** _____

Health Office Use only:

Reviewed by School Nurse _____ **Date** _____

School Nurse