Newgrange School
An extraordinary place to learn

The Laurel School
of Princeton

Health Office Guidelines and Documents

School Health Services
Nancy Silverberg
609-584-1800 ext. 229
Email: nsilverberg@thenewgrange.org

Dear Parent or Guardian:

Completion of the following forms is requested in order to facilitate school health care for your child.

Required

1. Student Emergency Contact Information
2. Physical Examination Form (To be completed by the Physician)
3. Annual Health History (To be completed by parent)
4. Health and Family Life Education (If you DO NOT want your child to participate)
5. Spinal Screening (If you DO NOT want your child to participate)

Fill out if applicable to your child

1. Emergency Medication Administration (Asthma or Life-Threatening allergy)
2. Health Care Plan (Food Intolerance)
3. Self-Administration of Medication
4. Request for Administration of Medication in School

***Please advise your child's bus driver if your student has a medical condition. It is especially important to advise the busdriver if your child has a condition, which could become a medical emergency, so that arrangements could be made to provide for healthcare.**

INSTRUCTIONS

1. Student Emergency Information Form
EMERGENCY FORMS ARE DUE ON THE FIRST DAY OF SCHOOL AND UPON ENROLLMENT! NO EXCEPTIONS! (in addition to forms requested from the main office).

2. Physical Examination Form - is requested every year.
The Newgrange School and New Jersey Administrative Code 6A:16-2.2 requires a report of physical examination from your child's primary care physician. It is **required** you submit this documentation upon enrollment and for each developmental time period.

- **Physical examination and immunization record documentation is required to be submitted upon entry into schoolas a new student or grade 3, grade 6, and grade 9.**
- **The physical examination documentation must include immunization record.**

3. Annual Health History Form - Must be completed by parent.

4. Health and Family Life Education Letter - Complete only if you ***do not*** want your child to participate in Family Life/Reproductive Health Education.

5. Spinal Screening (Starts in the 5th Grade)

Newgrange School
An extraordinary place to learn

The Laurel School
of Princeton

Complete only if you do not want your child to participate in Spinal (Scoliosis) Screening.

Fill out if applies to your child

1. Emergency Medication Administration (Asthma or Life-Threatening allergy) 2. Health Care Plan (Food Intolerance)
3. Self-Administration of Medication Administration

a. Authorize the principal and school nurse to permit the student to self-administer the prescribed medication as indicated. 4. Request for Administration of Medication in School

a. Included if you would like to request Tylenol or Motrin administered to your child as needed.

b. The administration of medication in school should be avoided whenever possible. The physician and the parent must complete a Request for Medication Form in order for medication to be administered by the school nurse.

Please contact Nancy Silverberg at 609-584-1800 extension 229 if you have questions.

Newgrange School
An extraordinary place to learn

The Laurel School
of Princeton

Health Office - Emergency Contact Form

Section 1 – Student Information

ID#	DOB	
Last Name	First Name MI	
Address		
City	Zip	Grade
Telephone:	Home School	Current Teacher/HR

To Parent or Guardian: To serve your child in case of accident or sudden Illness, it Is necessary that you give the following Information for emergency calls:

MOTHER/GUARDIAN'S FULL NAME	HOME TEL
Home Address (if different)	WORK TEL
	CELL
	EMAIL

FATHER/GUARDIAN'S FULL NAME	HOME TEL
Home Address (if different)	WORK TEL
	CELL
	EMAIL

List two neighbors or nearby relatives who will assume care of your child if you cannot be reached:

FULL NAME	HOME TEL
Address	WORK TEL
	CELL
RELATIONSHIP	EMAIL
FULL NAME	HOME TEL
Address	WORK TEL
	CELL
RELATIONSHIP	EMAIL

Please list any other children in the home attending New Jersey Public Schools:

Name	School

SECTION 2 – Medication Information

Does this child have any health Insurance, including NJFamilyCare/Medicaid, Medlcare, private or other?

____ Yes If yes, name of insurance company:_____

____ No NJ FamllyCare provides free or low cost for uninsured children and certain low-income parents. For more information call 800-701-0710 or visit www.nlfamilycare.org to apply online.

____ You may release my name and address to the Nl FamilyCare Program to contact me about health insurance.

Signature: _____ Printed Name:_____ Date:_____

Written consent required pursuant to 20 LI.S.C.S1232g(b%l) and 34 C.F.R.99.30 (b).

List and describe any medical/surgical care your child has received in the past year:

Dental Exam:	
Eye Exam:	Contacts?
Allergy:	Medications?
Allergic Reaction:	Medications?
Immunizations / Tetanus:	Type?
Restrictions:	

Doctor Name	Doctor Phone
Dentist Name	Dentist Phone
Hospital Name City	Hospital Phone

I, the undersigned, do hereby authorize officials of The Newgrange School and The Laurel School to contact directly the persons named on this card and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency for the health of said child. In the event that physicians, other persons named on this card, or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment for the health of the aforesaid child.

I will not hold the school financially responsible for the emergency care and/or transportation for said child.

Date: _____ Signature of Parent / Guardian: _____

PLEASE NOTIFY THE SCHOOL IMMEDIATELY OF CHANGES OR MODIFICATIONS TO ANY/ALL INFORMATION STATED.

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.

Newgrange School
An extraordinary place to learn

The Laurel School
of Princeton

ANNUAL HEALTH HISTORY
(To be Completed by Parent)
RETURN TO IN A SEPARATE ENVELOPE "ATTENTION SCHOOL NURSE"

STUDENT_____ DOB_____ GRADE _____

1. Allergies or allergic reactions including eczema or anaphylaxis (please explain) _____
   _____
2. Is the student under a physician's care? _____ If yes, for what condition? _____
   Who is the physician? _____
3. Is there any history of asthma / wheezing / reactive airway disease? (please explain) _____
   _____
4. Is there a medical history of neurological disease, seizure disorder, heart disease, hearing loss? _____
   If yes, please explain on the back of the form.
5. Note unusual frequency of upper respiratory conditions:
   _____Strep throat _____ Sinusitis _____Colds _____Earaches _____Other
   Is there a history of major injury, concussion, surgery and hospitalization? _____
   If yes, please explain on the back of the form:
6. Eating habits: vegetarian unusual habits special needs allergies. Please circle and explain.
   _____ Glasses _____ Contacts _____ Reading _____ Distance
7. Unusual sleeping patterns or problems? If yes, please explain on the back of the form.
8. Does your child have any restrictions or limitations? If yes, please explain: _____
   _____
9. Please list all medications your child is taking. Include purpose and type of administration. _____
   _____

HIGHLIGHTED ITEMS MUST BE DISCUSSED WITH THE NURSE

I give permission for the release of information on numbers: ____ or all ____ on this form for confidential use in meetings regarding my child's health and educational needs at Newgrange.
I desire a conference with the Nurse: _____Yes _____No

_____	_____	_____	_____
Parent/Guardian Signature	Date	Nurse Signature	Date

Newgrange School
An extraordinary place to learn

The Laurel School
of Princeton

School Health Services
Nancy Silverberg
609-584-1800 ext. 229
Email: nsilverberg@thenewgrange.org

STUDENT NAME:_____

Health and Family Life Education: Human Relationships and Sexuality

School Year 2021-2022

Dear Parent or Guardian:

The purpose of this letter is to provide notification of Health and Family Life Education lessons for your child's class this school year. This instruction can include lessons on sensitive topics related to puberty, sexuality, and personal hygiene. The material provided is for the purposes of implementing a program consistent with content outlined in New Jersey Core Curriculum Standard 2.4: Human Relationships and Sexuality. Pursuant to N.J.S.A. 18A:35-4.7, any child whose parent or guardian presents to the school a signed statement that any part of instruction in health, family life education, or sex education conflicts with his or her conscience or sincerely held moral or religious beliefs shall be excused from that portion of the course. The New Jersey Core Curriculum Standards can be found at

http://www.state.nj.us/education/cccs/standards/2/index.html

Also, please be aware that classroom instruction in science can include reproductive lessons, and counseling can include human relationship lessons, for example. Please be encouraged to discuss your questions regarding Health and Family Life Education with your child's teachers.

If you do not want your child to participate in Health and Family Life Education: Human Relationships and Sexuality:

Please complete and submit to The Newgrange School only if you do not want your child to participate in Health and Family Life Education: Human Relationships and Sexuality.

PLEASE CHECK:

_____ I **DO NOT** want my child to participate in Health and Family Life Education.

Parent or Guardian Signature_____Date _____

IT IS NOT NECESSARY TO SUBMIT THIS SIGNED DOCUMENT IF YOU DO WANT YOUR CHILD TO PARTICIPATE IN HEALTH AND FAMILY LIFE EDUCATION CLASS

Newgrange School
An extraordinary place to learn

The Laurel School
of Princeton

Spine Screening
School Year 2021-2022
(Starts in the 5th grade)

School Health Services
Nancy Silverberg
609-584-1800 ext. 229
Email: nsilverberg@thenewgrange.org

Dear Parents and Guardians:

The purpose of this letter is to inform you I will be performing spinal assessments in the school health office during the school year. I will notify you of findings only in cases where a referral is necessary. Students ages 10 to 18 are required by law to be evaluated for spinal curvature (possible scoliosis).

Boys and girls will be screened separately. Privacy is ensured. It is helpful when students wear a top that can be easily removed in order to allow assessment of the back.

Any student may be exempt from the examination upon the written request of the parent or guardian.

Please complete the bottom of this form and submit to the health office **only if you would like your child to be excused from the screening.**

Sincerely,
Nancy
Silverberg

Please Do Not Detach

Student Name: _____

Date:_____ Grade_____

1 DO NOT w is h to have my child participate in the scoliosis screening program. Please indicate one of the following:

- o My child has been/will be screened by our private physician (please provide medical note from physician).
- o Other (please indicate): _____

Parent/Guardian Name (please print): _____

Parent/Guardian Signature: _____

*Please complete this form for each school year you would like your child to be exempt from scoliosis screening.

The Laurel School of Princeton

21-22 Release for Emergency Medical Treatment

Dear Parents:

In case of a medical emergency, it is imperative that the school be able to insure adequate and appropriate treatment for your child. In order to do so, a medical release is necessary. Please complete the release below and return it immediately to school.

In the event of a medical emergency requiring professional medical attention while at school, your child will be taken to Capital Health by ambulance. You will be notified immediately. A designated staff member will accompany the child until you arrive.

I/We grant permission to The Laurel School to take my child _____, To an appropriate medical facility in order that he/she may be provided with emergency medical attention when required. I will not hold the school financially responsible for the emergency care and/or transportation of my child. Your signature below is not sufficient for the release of confidential information protected by law.

Special instructions: (Please indicate any allergies to medication, etc.)

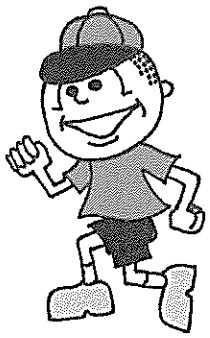
_____

_____

_____ _____

Date Signature of Parent or Guardian

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

"Your Pathway to Asthma Control"

PACNJ approved Plan available at www.pacnj.org

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 5U59EH000431-6. 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 XA96296601-2 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.

Sponsored by

AMERICAN LUNG ASSOCIATION. IN NEW JERSEY

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
☐ 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.

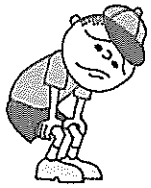
And/or Peak flow from_____ to_____

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.

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

REVISED AUGUST 2014

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

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): _____

_____

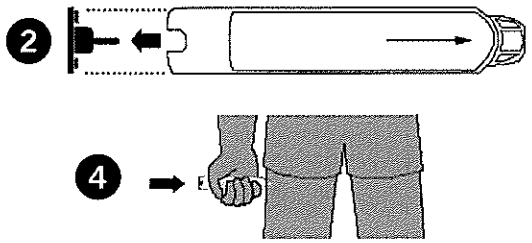
PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 3/2016

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

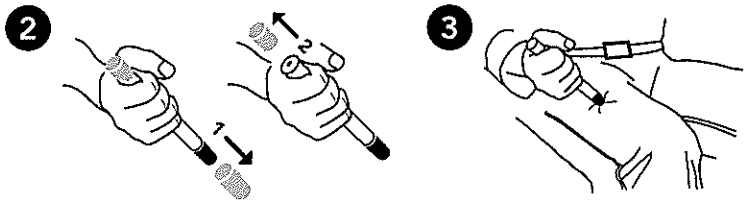
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

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.



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) 3/2016

Newgrange School
An extraordinary place to learn

The Laurel School
of Princeton

SELF-ADMINISTRATION OF MEDICATION FORM

N.J.S.A. 18A: 40-12.3 et seq. (Asthma Inhalers and Epi-pens Only)

School Health Services
Nancy Silverberg
609-584-1800 ext. 229
Email: nsilverberg@thenewgrange.org

Student Name:_____ Date of Birth: _____

PARENTAL REQUEST

I, the parent/guardian of_____, authorize the principal and the school nurse to permit the student to self-administer the prescribed medication as indicated. I understand and agree that the school, school nurse and principal shall incur no liability because of anyinjury arising from the self-administration of medication by the student and I hold harmless the school, school nurse and principal against any claims arising out of the self-administration of medication by the student.

The medication will be brought to school in its original container appropriately labeled by my pharmacy. This request will terminate automatically at the end of the school year.

Signature: _____ Date: _____
Parent/Guardian

PHYSICIAN'S STATEMENT

In order to protect the health of_____it is necessary for him/her to have the following medication during school hours.

Diagnosis: _____

Medication: _____

Dosage: _____

Time to be Administered: _____

Purpose of Medication: _____

Possible Side Effects: _____

Date to Begin/Conclude:
I request that the student be allowed to carry and self-administer the prescribed medications. I certify that the student understands, has received instruction in, and is capable of self-administration.

Licensed Health Care Professional authorizing administration of above medications:

_____ _____ _____
Signature of Physician | Print Physician's Name | Date

_____ _____
Address | Phone

_____ _____ _____
Demonstration Date(s) | School Nurse Signature | Date

AUTHORIZATION DATE: _____ _____
School Nurse

Newgrange School
An extraordinary place to learn

The Laurel School
of Princeton

REQUEST FOR ADMINISTRATION OF AS NEEDED MEDICATION IN SCHOOL

Student Information (Tylenol/Motrin)

Name _____ DOB:_____

Homeroom Teacher_____ Grade: _____

Parent Names(s)_____

Daytime Phone#: _____Alternate #: _____

List Student Allergies:_____

Other Medications:_____

Diagnosis:_____

Medication Information

Name of Medication:_____

Dose: _____ Time(s) to be administered_____

Route: ___ Orally ____Inhaled _____Injected _____Other: _____

Start Date:_____ End Date:_____

***Medication must be submitted to the school nurse by the parent/guardian in the original pharmacy labeled container.**
***Medication must be picked up at the end of the school year or be discarded.**

Consent

Medications should be administered a home whenever possible. The nurse may administer medications in the health office when it is necessary to support health and safety in school.

Date: _____ Physician's Signature_____

Physician Name (Stamp/Print): _____

I request the nurse administer the above medication.

Date: _____ Parent/Guardian Signature_____

Printed Name: _____ Relationship: _____

Request to administer medication terminates automatically at the end of the school year.
Please return this form to the Nancy Silverberg.
Phone: 609-584-1800 ext. 229 Email: nsilverberg@thenewgrange.org