PCSST SCHOOL NURSE PARENT LETTER

Dear Parents/ Guardians,

Welcome to a new and exciting school year 2025-2026! I am looking forward to a safe and healthy school year.
Please be sure to keep this letter for future reference!

TO REPORT AN ABSENCE: Please call 973-345-4400 **ext # 2407** if you have a concern that needs to be discussed with the nurse.

HEALTH RELATED CONCERNS: If your child is absent due to an illness, **a doctor's note must be provided for the absence to be excused.** If your child is not feeling well and you decide to keep her/ him home, you may notify the school Registrar or Nurse.

IF YOUR CHILD IS EXPERIENCING VOMITING, DIARRHEA, AND/OR FEVER, PLEASE KEEP THEM HOME. ALL STUDENTS MUST BE SYMPTOM FREE FOR 24 HRS UPON RETURNING TO SCHOOL.

PHYSICAL EXAMS: Each student is required to have a **yearly physical exam** completed by their doctor. ***All forms must be submitted to the Nurse***

MEDICATIONS: If your child needs to be given medication during school hours, a **PCSST medication administration form** must be completed by your child's doctor/physician or the medication **CANNOT** be administered. Please see following:

- All medications must be supplied in the **original prescription container** with the appropriate name on it.
- All medications are kept locked in the health office medication cabinet
- Please **DO NOT** send students to school with medications in their backpacks or pockets to take during the school day. Any medications found with students will be confiscated for safety reasons.
- Medications must be brought in/picked up by parents/guardians **ONLY.**

INHALERS AND NEBULIZERS: If your child uses an asthma inhaler, it should be kept in the health office unless your child is allowed to self-carry/administer as per MD order.
A nebulizer machine is provided in the health office. Parents are required to provide **tubing, masks and medications** as per MD orders.

****ASTHMA ACTION PLANS MUST BE SIGNED BY DOCTOR AND SUBMITTED TO HEALTH OFFICE****

ALLERGIES & EPINEPHRINE (EpiPen): The **ALLERGY ACTION PLAN** must be completed by your doctor and submitted to the health office. Please notify the school nurse if your child has any food, medication, insect or any other allergies. Life threatening allergies that require the use of EpiPen, must be reported to the nurse and student's teacher. Doctor's orders must be completed for the permission of administration of epinephrine and the student's individualized EpiPen must be submitted to the school nurse.

HEALTH SCREENINGS: State Law mandates health screenings are done on all students, which include height, weight, blood pressure, vision and hearing. If any abnormalities are found, a referral letter is sent home.

GYM EXCUSES: If your child needs to be excused from the gym, a doctor's note is required.
ALL GYM EXCLUSIONS ARE TO BE BROUGHT TO THE HEALTH OFFICE FIRST

IMMUNIZATIONS/ VACCINATIONS: If your child receives an immunization during the summer, please submit documentation to the school health office either during the summer program or on the first day of the school year.

****Students who are not up to date with their immunizations are not in compliance with NJ State Law and will be excluded from school until proper immunization documents are received.**

****All documents must be stamped/signed by their doctor.**

If you should have any further questions or concerns please contact the health office.

Phone# 973-345-4400 Ext. 2407 or email: mary.iacone@pcsst.org

Mary Iacone RN, BSN
PCSST School Nurse (4-7 Campus)

PATERSON CHARTER SCHOOL FOR SCIENCE AND TECHNOLOGY

4-7 Campus

276 Wabash Ave., Paterson NJ, 07503

HEALTH OFFICE INFORMATION PACKET AND FORMS

REQUIRED FOR SCHOOL ENTRY MUST BE RETURNED ON THE FIRST DAY OF THE SCHOOL YEAR.

1. **Turn in STATE MANDATED IMMUNIZATIONS** if indicated according to age/grade. Please see **page 2** and the chart provided in the health packet for required immunizations.
2. **Turn in UPDATED PHYSICAL (page 1)**. Must be completed by DOCTOR and updated physical must be completed and returned at the start of every school year.
3. **Complete Health Packet:**

- **Page 4 Authorization for Confidential Information Form**: RETURN EVERY SCHOOL YEAR Completed by PARENT and must be completed, signed and returned at the start of every school year
- **Page 5 Health Services Form: RETURN EVERY SCHOOL YEAR** Completed by PARENT and must be completed, signed, and returned at the start of every school year
- **Page 6 Medication Policy Form: RETURN EVERY SCHOOL YEAR** Completed by PARENT and must be completed, signed, and returned at the start of every school year
- **Page 7 Physician Order Form: ONLY IF MEDICATIONS ARE NEEDED**
  Completed by DOCTOR and PARENT
  Must be completed, signed, and returned at the start of every school year if a student requires medications in school. These include medications such as antibiotics or any over the counter medications such as tylenol, motrin, etc.

- **FARE (Food Allergy & Anaphylaxis Emergency Care Plan): ONLY IF STUDENT HAS FOOD or LIFE THREATENING ALLERGIES**
  - Completed by DOCTOR and PARENT
  - Must be completed, signed, and returned at the start of every school year if a student requires medications in school.
  - Please have physician complete Physician Order Form as well for EpiPen/Benadryl
- **Asthma Treatment Plan**: **ONLY IF STUDENT HAS ASTHMA**
  - Completed by DOCTOR and PARENT
  - Must be completed, signed, and returned at the start of every school year if student requires medications in school

4. Visit health office website on school page for further information.

PATERSON CHARTER SCHOOL FOR SCIENCE AND TECHNOLOGY
PHYSICAL EXAMINATION FORM

Name_____
Date of Birth_____
Grade_____Room_____
Height_____ Weight_____
Blood Pressure_____
Nutrition_____
Posture_____
Skin_____
Eyes/eyelids_____
Vision Acuity R_____L_____
Vision with Glasses R_____L_____
Hearing results: R_____L_____
Nose_____
Throat_____
Teeth/Gums_____
Lymph Nodes:_____
Heart_____
Lungs_____
Spine/ Joints_____
Scoliosis_____

Feet_____
Nervous system_____
Deformities_____

Physician's Name Printed or use stamp:

_____

Physician's signature:

_____

Immunizations

DPT/DaPT (Circle Type)
#1_____#2_____#3_____
Booster#1_____#2_____
OPV/IPV (Circle type)
#1_____#2_____#3_____
Booster#1_____#2_____
MMR#1_____#2_____
#3_____#4_____
HIB #1_____#2_____
#3_____#4_____

Hepatitis B
#1_____#2_____#3_____
Varivax_____
Meningococcal_____
PPD Intradermal Date_____
Result_____mm
REMARKS: Please indicate any known allergies, medical conditions, medications and any restrictions for physical activities.

_____
_____

Full participation in school activities is permitted.
_____YES _____NO

DATE OF PHYSICAL EXAMINATION:_____

RETURN TO SCHOOL NURSE

PATERSON CHARTER SCHOOL FOR SCIENCE AND TECHNOLOGY (4-7 Campus)

276 Wabash Ave. Paterson., NJ 07503

Name _____ **Date of Birth** _____

Grade _____

Dear Parents/ Guardians:

According to the New Jersey Sanitary Code, Chapter 14; NJ Administrative Code 8:57-4:17, **no student may remain in school who has not submitted acceptable evidence of immunization against disease to the School Health Office**.

_____1. DtaP series (4-5)

_____ 2. TD (**age 11**)

_____3. Hib series (1 required, should have up to 4)

_____4. Pneumococcal (1 required, should have up to 4)

_____5. Hep A series (2)

_____6. Hep B series (3)

_____7. IPV/OPV-Polio (3-4)

_____8. Varicella (2)

_____9. MMR (2)

_____10. Meningococcal (**age 11**)

_____11. Tuberculin Skin Test – Intradermal Mantoux – **Date and Results**

Documentation of the requirements must be presented to the nurse as soon as possible. Your child will not be able to attend the 1st day of school and will lose his/her enrollment if vaccination records are not provided.

New Jersey Department of Health

MINIMUM IMMUNIZATION REQUIREMENTS FOR SCHOOL ATTENDANCE IN NEW JERSEY
N.J.A.C. 8:57-4: IMMUNIZATION OF PUPILS IN SCHOOL

Disease(s)	Meets Immunization Requirements	Comments
DTaP//DTP	Age 1-6 years: 4 doses, with one dose given on or after the 4th birthday, OR any 5 doses. Age 7-9 years: 3 doses of Td or any previously administered combination of DTP, DTaP, and DT to equal 3 doses	Any child entering pre-school, and/or pre-Kindergarten needs a minimum of 4 doses. A booster dose is needed on or after the fourth birthday, to be in compliance with Kindergarten attendance requirements. Pupils after the seventh birthday should receive adult type Td. Please note: there is no acceptable titer test for pertussis.
Tdap	Grade 6 (or comparable age level for special education programs): 1 dose	For pupils entering Grade 6 on or after 9-1-08 and born on or after 1-1-97. A child is not required to have a Tdap dose until FIVE years after the last DTP/DTaP or Td dose.
Polio	Age 1-6 years: 3 doses, with one dose given on or after the 4th birthday, OR any 4 doses. Age 7 or Older: Any 3 doses	Any child entering pre-school, and/or pre-Kindergarten needs a minimum of 3 doses. A booster dose is needed on or after the fourth birthday to be in compliance with Kindergarten attendance requirements. Either Inactivated polio vaccine (IPV) or oral polio vaccine (OPV) separately or in combination is acceptable. Polio vaccine is not required of pupils 18 years or older.*
Measles	If born before 1-1-90, 1 dose of a live measles-containing vaccine on or after the first birthday. If born on or after 1-1-90, 2 doses of a live measles-containing vaccine on or after the first birthday.	Any child over 15 months of age entering child care, pre-school, or pre-Kindergarten needs a minimum of 1 dose of measles vaccine. Any child entering Kindergarten needs 2 doses. Intervals between first and second measles-containing vaccine doses cannot be less than 1 month. Laboratory evidence of immunity is acceptable.**
Rubella and Mumps	1 dose of live mumps-containing vaccine on or after the first birthday. 1 dose of live rubella-containing vaccine on or after the first birthday	Any child over 15 months of age entering child care, pre-school, or pre-Kindergarten needs 1 dose of rubella and mumps vaccine. Any child entering Kindergarten needs 1 dose each. Laboratory evidence of immunity is acceptable. **
Varicella	1 dose on or after the first birthday	All children 19 months of age and older enrolled into a child care/pre-school center after 9-1-04 or children born on or after 1-1-98 entering the school for the first time in Kindergarten or Grade 1 need 1 dose of varicella vaccine. Laboratory evidence of immunity, physician's statement or a parental statement of previous varicella disease is acceptable.
Haemophilus influenzae B (Hib)	Age 2-11 Months: 2 doses Age 12-59 Months: 1 dose	Mandated only for children enrolled in child care, pre-school, or pre-Kindergarten: Minimum of 2 doses of Hib-containing vaccine is needed if between the ages of 2-11 months. Minimum of 1 dose of Hib-containing vaccine is needed after the first birthday. ***
Hepatitis B	K-Grade 12: 3 doses or Age 11-15 years: 2 doses	If a child is between 11-15 years of age and has not received 3 prior doses of Hepatitis B then the child is eligible to receive 2-dose Hepatitis B Adolescent formulation.
Pneumococcal	Age 2-11 months: 2 doses Age 12-59 months: 1 dose	Mandated only for children enrolled in child care, pre-school, or pre-Kindergarten: Minimum of 2 doses of pneumococcal conjugate vaccine is needed if between the ages of 2-11 months. Minimum of 1 dose of pneumococcal conjugate vaccine is needed after the first birthday. ***
Meningococcal	Entering Grade 6 (or comparable age level for Special Ed programs): 1 dose	For pupils entering Grade 6 on or after 9-1-08 and born on or after 1-1-97. *** This applies to students when they turn 11 years of age and attending Grade 6.
Influenza	Ages 6-59 Months: 1 dose annually	For children enrolled in child care, pre-school, or pre-Kindergarten on or after 9-1-08. 1 dose to be given between September 1 and December 31 of each year. Students entering school after December 31 up until March 31 must receive 1 dose since it is still flu season during this time period.

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New Jersey Department of Health

MINIMUM IMMUNIZATION REQUIREMENTS FOR SCHOOL ATTENDANCE IN NEW JERSEY
N.J.A.C. 8:57-4: IMMUNIZATION OF PUPILS IN SCHOOL

*** Footnote:** The requirement to receive a school entry booster dose of DTP or DTaP after the child's 4th birthday shall not apply to children while in child care centers, preschool or pre-kindergarten classes or programs.

The requirement to receive a school entry dose of OPV or IPV after the child's 4th birthday shall not apply to children while in child care centers, preschool or pre-kindergarten classes or programs.

**** Footnote:** Antibody Titer Law (Holly's Law)—This law specifies that a titer test demonstrating immunity be accepted in lieu of receiving the second dose of measles-containing vaccine. The tests used to document immunity must be approved by the U.S. Food and Drug Administration (FDA) for this purpose and performed by a laboratory that is CLIA certified.

***** Footnote:** No acceptable immunity tests currently exist for Haemophilus Influenzae type B, Pneumococcal, and Meningococcal.

Please Note The Following:

The specific vaccines and the number of doses required are intended to establish the minimum vaccine requirements for child-care center, preschool, or school entry and attendance in New Jersey. These intervals are not based on the allotted time to receive vaccinations. The intervals indicate the vaccine doses needed at earliest age at school entry. Additional vaccines, vaccine doses, and proper spacing between vaccine doses are recommended by the Department in accordance with the guidelines of the American Academy of Pediatrics (AAP) and Advisory Committee on Immunization Practices (ACIP), as periodically revised, for optimal protection and additional vaccines or vaccine doses may be administered, although they are not required for school attendance unless otherwise specified.

Serologic evidence of immunity (titer testing) is only accepted as proof of immunity when no vaccination documentation can be provided or prior history is questionable. It cannot be used in lieu of receiving the full recommended vaccinations.

Provisional Admission:

Provisional admission allows a child to enter/attend school after having received a minimum of one dose of each of the required vaccines. Pupils must be actively in the process of completing the series. Pupils <5 years of age, must receive the required vaccines within 17 months in accordance with the ACIP recommended minimum vaccination interval schedule. Pupils 5 years of age and older, must receive the required vaccines within 12 months in accordance with the ACIP recommended minimum vaccination interval schedule.

Grace Periods:

- 4-day grace period: All vaccine doses administered less than or equal to four days before either the specified minimum age or dose spacing interval shall be counted as valid and shall not require revaccination in order to enter or remain in a school, pre-school, or child care facility.
- 30-day grace period: Those children transferring into a New Jersey school, pre-school, or child care center from out of state/out of country may be allowed a 30-day grace period in order to obtain past immunization documentation before provisional status shall begin.

PATERSON CHARTER SCHOOL
FOR SCIENCE AND TECHNOLOGY
4-7 Campus
276 Wabash Ave.
Paterson, NJ 07503

School Health Services

AUTHORIZATION FOR THE EXCHANGE OF CONFIDENTIAL INFORMATION

Student_____ **Date:**_____

Date of Birth_____ **Grade:**_____

As the parent/guardian of the above named student, I hereby authorize the release of pertinent medical information (medical conditions, allergies, medication regimens) to be exchanged among appropriate professional staff involved in the care of my child. This consent is valid for the _____ school year and is intended to allow the staff to better serve my child.

Sincerely,

Mary Iacone
School Nurse

_____
Signature of Parent/ Guardian

_____
Date

FORM MUST BE COMPLETED AND RETURNED TO SCHOOL NURSE AT THE BEGINNING OF EACH SCHOOL YEAR

PATERSON CHARTER SCHOOL FOR SCIENCE AND TECHNOLOGY

SCHOOL HEALTH SERVICES (completed by parent)

STUDENT NAME: _____ BIRTHDATE _____

Please check the appropriate medical condition that applies. Give a brief explanation in the space provided.

_____ No Known Health Problems
_____ ADD/ADHD
_____ Allergy-Bee sting (Benadryl) can be given, should carry own epi-pen)
_____ Allergy-Food (must have Dr.'s note for special dietary needs for hot lunch)
_____ Allergy-General (medication, seasonal, hay fever)
_____ Arthritis
_____ Asthma/Inhaler (may be carried in school, separate form to be completed)
_____ Birth Defect/Chromosome Disorder
_____ Blood Disorder
_____ Bowel Disorder
_____ Cancer
_____ Cerebral Palsy
_____ Cystic Fibrosis
_____ Depression
_____ Diabetes
_____ Ear Infections
_____ Epilepsy/Seizures
_____ Headaches
_____ Hearing Loss: Right ear _____ Left ear _____ Both _____ Hearing Aids _____
_____ Kidney Disorder
_____ Muscular Dystrophy
_____ Nose Bleeds (frequent)
_____ Scoliosis/brace
_____ Sickle Cell
_____ Tourette Syndrome
_____ Tuberculosis
_____ Vision Impairment: glasses/contacts. Any concerns? (vision can be tested at school)
_____ OTHER:
_____ Has student ever had surgery? If so, for what?

EXPLANATION: _____
_____

MEDICATION: (Name & Dosage) _____ (Authorization form is to be completed if medication is given at school...ask the nurse)

PARENT/GUARDIAN SIGNATURE _____ DATE _____

FORM MUST BE COMPLETED & RETURNED TO SCHOOL NURSE AT THE BEGINNING OF EACH SCHOOL YEAR

PATERSON CHARTER SCHOOL
FOR SCIENCE AND TECHNOLOGY
276 Wabash Ave.
Paterson NJ, 07503

MEDICATION POLICY

MUST BE COMPLETED AND RETURNED TO SCHOOL NURSE AT THE BEGINNING OF EACH SCHOOL YEAR

PLEASE NOTE: *Parents are advised to give non-emergency medications before school, after school, and before bedtime as needed. Medication is administered for chronic illness and/or emergency cases.* **NO OVER THE COUNTER MEDICATIONS (Tylenol, Advil/Motrin, etc.) WILL BE PROVIDED WITHOUT A PHYSICIAN'S WRITTEN ORDER.**

Medication must follow the following criteria:

1. The certified school nurse or parent/guardian is the only person permitted to administer medication at school (N.J.S.A. 45:11-37). **DO NOT SEND YOUR CHILD TO SCHOOL WITH MEDICATION WITHOUT PERMISSION FROM SCHOOL NURSE.**
2. Parent/guardian must provide the school nurse with physician's orders on the PCSST approved form including name of drug, dosage, side-effect, and time of administration.
3. Medication must be clearly labeled, unopened in the original container, and have the full count/dosage as labeled on the container.
4. Parent/guardian must sign the consent form granting the school nurse permission to administer the medication.
5. Parent/guardian is responsible for the administration of medication if the school nurse is unavailable.
6. The school nurse will discard medication not retrieved by the parent/guardian at the end of the school year.
7. If a parent does not respond to a nurse's call to pick up a student in case of an emergency, 911 will be called for the safety and health of the student.
8. Self-administration of medication for chronic conditions (e.g. respiratory conditions) will be permitted with the written order of the physician and signed authorization by the parent/guardian.

_____ _____

Student's name **Date**

_____

Parent signature

PATERSON CHARTER SCHOOL FOR SCIENCE AND TECHNOLOGY

4-7 Campus

276 Wabash Ave., Paterson NJ 07503

SCHOOL MEDICATION/ PHYSICIAN ORDER AND PARENT AUTHORIZATION FORM

MUST BE COMPLETED AND RETURN TO SCHOOL NURSE FOR STUDENT RECEIVING ANY MEDICATIONS IN SCHOOL

PHYSICIAN'S ORDER

I hereby request and authorize you to give:

Medication name Dose Time and Frequency Route Duration

_____

_____

_____

Diagnosis/ Medical reason for medication:_____

Side effects:_____

Physician's signature:_____Date:_____

Print Physician's Name:_____ Phone No:_____

Clinic Name & Address:_____Fax No:_____

Name:_____ Date: _____

DOB:_____

PARENT/GUARDIAN AUTHORIZATION:

1. I request that the above medication be given during school hours as ordered by the physician.
2. I release school personnel from any liability to this request when the medication is given as ordered.
3. We will notify the school of any change in the medication (name, dose, etc, prior to the time stated in the doctor's order).
4. I give permission to the school nurse to communicate with the teachers/ staff about the action and side effects of this medication.
5. I give permission to the school nurse to consult with the above named physician regarding any questions that arise with regard to the medication listed above or medical condition being treated by this medication.
6. FIELD TRIPS: I give permission for the assigned teacher/ responsible adult to administer the medication on a field trip, as necessary, following school procedure.

Signature of Parent/ Guardian:_____Date:_____

Relationship to student:_____Phone No:_____

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

(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.

Disclaimer: The use of this Asthma Treatment Plan does not create, and your use of it does not establish, a physician-patient relationship between you and the New Jersey Asthma Coalition or the New Jersey Asthma Alliance (NJAA) or any of their officers, directors, employees, agents, or committees. Under no circumstances will the NJAA or any of its officers, directors, employees, agents, or committees be liable to you or your heirs or estate for any damages, including but not limited to direct, indirect, incidental, consequential, punitive, or exemplary damages, arising from or relating to your use of this Asthma Treatment Plan, or to the NJAA. The NJAA makes no representation or warranty about the accuracy, reliability, completeness, currency, or timeliness of the content, advice, or services provided through this Asthma Treatment Plan. You acknowledge that any reliance upon any such content, advice, or services is solely at your own risk. You agree that the NJAA will not be liable for any damages, including but not limited to direct, indirect, incidental, consequential, punitive, or exemplary damages, arising from or relating to your use of this Asthma Treatment Plan, or to the NJAA.

This Asthma Treatment Plan was developed by the New Jersey Asthma Coalition, 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 5 U58EH000941-04. 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 was developed under a grant from the United States Environmental Protection Agency under Agreement XA97389901-0 to the American Lung Association in New Jersey, it has not gone through the Agency's publication review process and therefore may not necessarily reflect the views of the Agency and no official endorsement should be inferred. Information on this publication is not a substitute for diagnosis, health problems or prescription of medication. For asthma or any medical concern, seek medical advice from your health care professional.

REVISED MAY 2017

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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_____

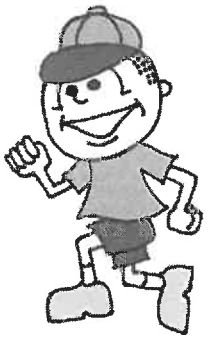
Physician's Orders

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

PATERSON CHARTER SCHOOL FOR SCIENCE AND TECHNOLOGY

4-7 Campus

276 Wabash Ave. Paterson NJ 07503

EPINEPHRINE PERMISSION FORM

Paterson Charter School for Science and Technology requires that all students who may need medication during school hours must do the following:

1. Present doctor's note/orders stating the name of medication, dosage, diagnosis, and length of time medication is to be given.
2. Present written consent by the parent/guardian.
3. Bring the medication to school in the original prescription bottle, properly labeled by a registered pharmacist as prescribed by the law.
4. The Board shall permit the school nurse to administer epinephrine via pre-filled auto injector in emergency situations. If needed, a designee who is employed by the Board may administer the epinephrine in the event the nurse is not present.

Administration of Epinephrine – Physician's Orders

Student's Name:_____ **DOB:** _____ **Grade:** _____

I have documented symptoms of anaphylaxis for the above named student.

Symptoms include:_____

EPINEPHRINE ORDERS:

Name:_____ **Dose:**_____ **Route:**_____

Time & Frequency: _____ **Duration:**

_____

ANTIHISTAMINE (IF ANY) ORDERS:

Name: _____ **Concentration:**_____ **Dose:**_____

Route: _____ **Time & Frequency:** _____ **Duration:**_____

This student requires the administration of epinephrine via a pre-filled single or double dose auto-injector mechanism for anaphylaxis. Please arrange for administration of epinephrine by the School Nurse, or in the absence of the School Nurse, administration by a delegate school employee designated by the School Nurse.

Signature of Physician: _____ **Date:** _____

Name of Physician: _____ **Phone #:** _____

I, parent/guardian of my above named student, authorize the emergency administration of epinephrine via a pre-filled, single or double dose auto-injector mechanism for anaphylaxis in accordance with these written orders. I understand that the law requires that should epinephrine be administered, my son/daughter will be transported to a hospital emergency room by emergency services personnel regardless of his/her condition even if the symptoms appear to have resolved.

Signature of Parent: _____ **Date:** _____

Name of Parent: _____ **Phone #:** _____

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

Name: _____ D.O.B.: _____

Allergic 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 allergens: _____

THEREFORE:

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

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

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Shortness of breath, wheezing, repetitive cough

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

THROAT
Tight or hoarse throat, trouble breathing or swallowing

MOUTH
Significant swelling of the tongue or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

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

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are 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** SYSTEM AREA, GIVE EPINEPHRINE.

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

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

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

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

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

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

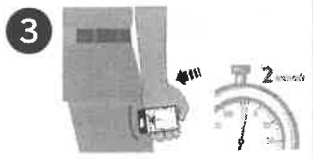
_____

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

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

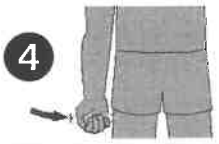
FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

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



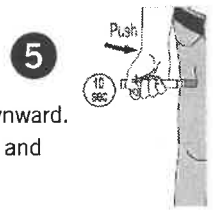
1. Remove Auvi-Q from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.

HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN



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

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.):

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

EMERGENCY CONTACTS — CALL 911

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) 5/2020

SEIZURE ACTION PLAN

Effective Date: _____

EPILEPSY FOUNDATION®

This child is being treated for a seizure disorder. This information below should assist you if a seizure occurs during childcare hours.

Child's Name	Date of Birth	
Parent/Guardian	Phone	Cell
Other Emergency Contact	Phone	Cell
Treating Physician	Phone	
Significant Medical History		

Seizure Information

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs:

Child response after a seizure:

Basic First Aid: Care and Comfort

Please describe basic first aid procedures:

Does the child need to leave the other children to recover? ☐ Yes ☐ No

If YES, describe process for returning child to interact with others:

Basic Seizure First Aid

- Stay calm & track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious

For tonic-clonic seizure:

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

Emergency Response

A "seizure emergency" for this child is defined as:

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

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

A seizure is generally considered an emergency when:

- Convulsive (tonic-clonic)seizure lasts longer than 5 minutes
- Child has repeated seizures without regaining consciousness
- Child is injured or has diabetes
- Child has a first-time seizure
- Child has breathing difficulties
- Child has a seizure in water

Treatment Protocol During Childcare Hours (include daily and emergency medications)

Emerg. Med.	Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Does child have a Vagus Nerve Stimulator? ☐ Yes ☐ No If YES, describe magnet use:

Special Considerations and Precautions (regarding activities, sports, trips, etc.)

Describe any special considerations or precautions:

Physician Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____