PCSST SCHOOL NURSE PARENT LETTER

Dear

Parents/Guardians,

Welcome to the 2020-2021` school year! We are looking forward to a safe and healthy school year.

We would like to outline some of the guidelines regarding the Health Office here at PCSST. Please keep this letter for future reference.

Health Related Concerns

If your child is absence due to an illness a Doctor's note must be provided for the absence to be excused. If the child is not feeling well and as the parent you decide to keep them home. Please always notify the school staff or Nurse. **Keep in mind only Doctor's Notes can excuse an absence (For more detailed information please see school student handbook.)**
***If your child has excessive vomiting, diarrhea, or fever please keep child home. All students must be fever free for T .100 or greater for 24hour any question please call School Nurse. Always notify School.**

MEDICATIONS

If your child needs to take medication during the school day, a medication permission sheet must be filled out for each medication your child is taking, completed by the child's doctor or the medication will not be dispensed.

- All medications must be supplied in the original or prescription container with student name on it.
- All medications must be kept in the Health Office.
- Medication will not be given to students without written permission from a parent/guardian.
- Please do not send medication to school in baggies or envelopes; it will be discarded. These guidelines are for the safety and protection of all the students.
- ***Medications must be brought in by adults only by the end of the first week of school.***

Inhalers and Nebulizers Medication

If your child uses an inhaler, it should be kept in the Health Office. If you feel that your child needs to carry his/her inhaler with him/her at all times, please discuss this with the nurse so that the appropriate paperwork can be filled out. The Health Office at the school has a nebulizer machine. If your child should need to take breathing treatments, ***you will need to supply the tubing, or face mask, medication, and doctor's medication permission form.***

***Asthma Action Plan must be completed by Doctor and submitted to School Nurse Office**

Allergies & Epinephrine at School

***Allergy Action Plan/EAP must be completed by Doctor and submitted to School Nurse Office**
Please make know to school nurse/ school if your child has any food, insect, or other allergies. If your child has any life threating allergies, that requires the use of an Epi-Pen. **Please notify the school nurse**

& teacher. ***A Doctor's note and permission for administration of Epinephrine must be completed and the EpiPen (labeled with student's name from pharmacy) must be submitted to school nurse.***

Field Trip Medication

Any student, who has asthma and or taking medication on regularly or as needed bases, will require written permission to attend field trip and instructions on medication administration.

Health Screenings

State Law mandates Health screening are done on all students. The Screening consists of height, weight, blood pressure, vision and hearing screening & (scoliosis screening for age 10 and older). Any abnormal findings, a referral letter and phone will be made to notify you from the School Nurse.

Physical Exams

Each Student should have a yearly updated Physical Exam and immunizations updated. And all Physical Forms are to be submitted to the Nurse to be filed in the student's health records.

PE/ Gym Excuses

If your child needs to be excused from P.E., please send him/her with a note explaining why and specifically for how long they need to be excused. Students needing to be excused from P.E. longer than one day will need to have a note supplied by their physician. Your child should bring any P.E. excuses to the Health Office BEFORE (not to PE/classroom teachers) school. Please be advised that if your child is excused from P.E., his/her activities at recess time will be restricted also.

***Phone Numbers & Address**

It is very important that we have current phone numbers, address & emails! If you have changed residences or jobs during the summer, please update the phone numbers. If the area codes of home and/or work numbers have changed, please let us know. If you do not have a phone at home, please provide us with a phone number of a reliable friend or relative that can reach you in an emergency.

Immunizations:

If your child received an immunization during the summer, please contact us so that we may update their health record. ***Students who are not up-to-date with their immunizations are not in compliance with New Jersey State Law and may be excluded from school.*** All students must have on file documentation of immunizations by the physician or shot clinic with their signature or stamp.

*****All Immunizations must be up to date by the first day of school, in order to be compliant with New Jersey State Law, and PCSST Guidelines and Requirements, as well as an updated or current physical*****

Head Lice Bugging You

Occasionally head lice are a problem among school children. We have had several outbreaks in the past school year due to children being sent to school with head lice without the school or health office being made aware. Head lice are pesky critters and are passed only by direct contact with another child's hair or something used by that child such as a hat or brush. We suggest that you take a look at your child's hair at least once a week. If your child contracts head lice, it is important to let the school nurse know. Please don't send them to school.

Your children are important to us. I look forward to getting to know them and you this school year. If you have any questions or concerns, I am always happy to talk with you. Please stop at the Main Office at the school. I also can be reached via email at kathleen.bewighouse@pcsst.org

Mrs. Kathleen
Bewighouse, RN, BSN-CSN
PCSST K-1 School Nurse
973-333-4729

PATERSON CHARTER SCHOOL FOR SCIENCE AND TECHNOLOGY
K-1st Grade Campus
55 Main Street, Paterson, NJ 07505
Telephone: 973-333-4729 Fax: (973) 784-1088

HEALTH OFFICE INFORMATION PACKET AND FORMS

REQUIRED FOR SCHOOL ENTRY

MUST BE RETURNED AS SOON AS POSSIBLE OR BY AUGUST 10TH

1. Turn in **STATE MANDATED IMMUNIZATIONS** if indicated according to age/grade. Please see page 2 and chart provided in 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 student requires medications in school. These include medications such as: allergy medications, antibiotics, or any over the counter medications (Tylenol, Motrin, cough drops, etc.)
   - Page 8 Epinephrine Permission Form: ONLY IF EPI PEN IS NEEDED
     - Completed by **DOCTOR** and **PARENT**
     - Must be **completed, signed, and returned** at the start of every school year if student requires Epi Pen for any allergies
   - 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 student requires medications in school.
     - Please have physician complete Epinephrine Permission Form for Epi Pen/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 asthma medications in school
4. Visit health office website on school page for further information: http://www.pcsst.org/k6/12242-2/

PATERSON CHARTER SCHOOL FOR SCIENCE AND TECHNOLOGY

K-1st GRADE CAMPUS

Name _____ **BIRTHDATE** _____

GRADE _____

Dear Parents:

According to the New Jersey Sanitary Code, Chapter 14; NJ Administrative Code 8:57-4:17, no pupil may remain in school who has not submitted acceptable evidence of immunization against disease to the School Health Office. You are being notified that your child has not fulfilled the requirements HIGHLIGHTED below.

_____1. DtaP series (4-5)

_____2. TD (by 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 (by age 11)

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

Documentation of the requirements highlighted 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.

Your cooperation is much appreciated. Please feel free to contact me with any questions/concerns regarding your child's immunization status.

School Nurse: *Mrs. Bewighouse*

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.

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

PHYSICAL EXAMINATION FORM

UP TO DATE PHYSICAL MUST BE COMPLETED & RETURNED TO SCHOOL NURSE AT THE BEGINNING OF EACH SCHOOL YEAR

Name _____

Date of Birth _____ Grade _____

Height _____ Weight _____

Blood Pressure _____

Nutrition _____

Posture _____

Skin _____

Eyes/Lids _____

Vision Acuity R _____ L _____

Vision with Glasses R _____ L _____

Nose _____

Throat _____

Teeth/Gums _____

Lymph Nodes _____

Heart _____

Lungs _____

Spine/joints _____

Scoliosis _____

Feet _____

Nervous System _____

Deformities _____

_____

Physician's signature

_____

Physician Name Printed or use STAMP:

_____

Date of Physical Examination

IMMUNIZATIONS

DTAP

#1 _____ #2 _____ #3_____

Booster #1 _____ Booster #2 _____

OPV/IPV (Circle Type)

#1 _____ #2 _____#3 _____

Booster #1 _____

MMR

#1 _____ #2 _____

#3 _____ #4 _____

HIB

#1 _____ #2 _____

#3 _____ #4 _____

Hepatitis B

#1 _____ #2 _____ #3 _____

Varivax _____

Tdap _____

Meningococcal _____

PPD Intradermal

Date _____

Results _____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 _____

PATERSON CHARTER SCHOOL
FOR SCIENCE AND TECHNOLOGY

55 Main Street
Paterson, New Jersey 07505

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,

Mrs. Bewighouse
Mrs. Bewighouse, 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

55 Main Street
Paterson, New Jersey 07505

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, Cough Drops, 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 original container, and have the full count/dosage as labeled on 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 parent does not respond to nurse's call to pick up student in case of 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 Name

_____

Parent Signature

_____

Date

PATERSON CHARTER SCHOOL FOR SCIENCE AND TECHNOLOGY

K-1 Campus
55 Main Street, Paterson, NJ 07505

SCHOOL MEDICATION/PHYSICIAN ORDER AND PARENT AUTHORIZATION FORM

MUST BE COMPLETED AND RETURNED TO SCHOOL NURSE FOR STUDENT RECEVING ANY MEDICATIONS IN SCHOOL

PHYSICIANS 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 Signature: _____ Date: _____

Print Physician Name: _____ Phone No: _____

Clinic Name & Address: _____ Fax No: _____

Name: _____ **Date:** _____

DOB: _____

PARENT/GUARDIAN AUTHORIZATION:

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

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	Parent/Guardian (if applicable)	Emergency Contact	
Phone	Phone	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 ________

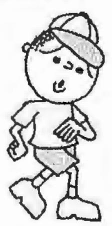
Take daily control medicine(s). Some inhalers may be more effective with a "spacer" – use if directed.

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.

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

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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 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
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 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/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 or Generic: _____

Epinephrine Dose: ☐ 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

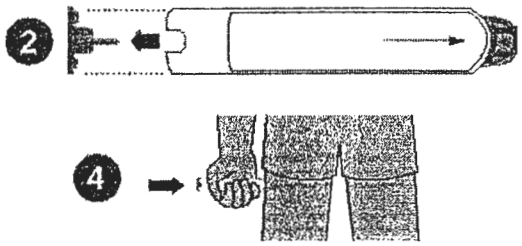
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 7/2016

FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

EPIPEN® AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the clear carrier tube.
2. Remove the blue safety release by pulling straight up without bending or twisting it.
3. Swing and firmly push orange tip against mid-outer thigh until it 'clicks'.
4. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove auto-injector from the thigh and massage the injection area for 10 seconds.



ADRENACLICK® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR 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 enters thigh.
5. Hold in place for 10 seconds. Remove from thigh.

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: _____

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 7/2016

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 _____