PCSST SCHOOL NURSE PARENT LETTER

Dear Parents/Guardians,

Welcome to a new and exciting school year! I am looking forward to a safe, healthy and prosperous educational year.

I would like to outline some important PCSST Health Office guidelines. Please be sure to keep this letter for future reference, questions and/or concerns.

TO REPORT AN ABSENCE: Please call **973.247.0600** and follow the prompt. If you have a concern that needs to be discussed with the nurse, please dial **ext. 1115**.

HEALTH RELATED CONCERNS: If your child is absent due to an illness, an MD note must be provided for the absence to be excused. If your child is not feeling well and you decide to keep them home, please notify the school Registrar or Nurse. ****ONLY MD NOTES CAN EXCUSE AN ABSENCE****

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

MEDICATIONS: If your child needs to be given medication during school hours, a PCSST medication administration form must be completed by your MD 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 cart.
- Please **DO NOT** send medication to school in zip-lock bags or envelopes; it will be discarded. This is required to maintain the safety and protection of all students.
- Medications must be brought in by parents/guardians **ONLY**.

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

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

ALLERGIES & EPINEPHRINE AT SCHOOL: The Allergy Action Plan must be completed by your MD 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 an EPI-PEN, must be reported to the nurse and students teachers. MD orders must be completed for the permission of administration of epinephrine and the student's individualized Epi-Pen must be submitted to the school nurse.

FIELD TRIP MEDICATIONS: Any students taking daily medications will require written permission to attend field trips and instructions on medication administration.

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.

PHYSICAL EXAMS: Each student is required to have a yearly physical exam. **All forms are submitted to the Nurse**

GYM EXCUSES: If your child needs to be excused from gym, an MD note is required. ****ALL GYM EXCLUSIONS ARE TO Be BROUGHT TO THE HEALTH OFFICE FIRST****

IMMUNIZATIONS: If your child received an immunization during the summer, please contact the health office so I can update their health record. **Students who are not up-to-date with their immunizations are not in compliance with NJ State Law and will be excluded until proper immunization documents are received. **All documents must be stamped or signed by their physician****

If you should have any further questions or concerns please contact the health office. **973.247.0600 EXT. 1115** or suzanne.buccolo@pcsst.org.

Suzanne Buccolo RN, BSN-CSN

7-12 Campus – School Nurse

PATERSON CHARTER SCHOOL FOR SCIENCE AND TECHNOLOGY PHYSICAL EXAMINATION FORM

Name_____

Date of Birth_____

Grade _____ Room_____

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 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

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

196 W. RAILWAY AVE.
PATERSON, NJ 07503
SCHOOL HEALTH SERVICES

AUTHORIZATION FOR THE EXCHANGE OF CONFIDENTIAL INFORMATION

STUDENT _____ DATE _____

DATE OF BIRTH _____ GRADE _____

SCHOOL YEAR _____

AS THE PARENT/GUARDIAN OF THE ABOVE NAMED STUDENT, I HEREBY AUTHORIZE THE RELEASE OF PERTINENT MEDICAL INFORMATION (CONDITIONS, ALLERGIES, MEDICATION) 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 FOR STAFF TO BETTER SERVE MY CHILD.

_____
SIGNATURE OF PARENT/GUARDIAN

_____
DATE

PLEASE RETURN TO HEALTH OFFICE

Paterson Charter School for Science and Technology

Phone: (973) 247-0600 Fax: (973) 247-9924 Web: www.pcsst.org

SCHOOL MEDICATION/PHYSICIAN ORDER FORM

Name of student _____ DOB _____

Diagnosis/medical reason for medication_____

Date medication begins _____ Date medication ends _____

Name of medication _____

Dose _____ Route _____ Frequency _____

Side Effects: _____

Name of Health Care Provider (PRINT) _____

Signature of Health Care Provider _____

Health Care Provider address _____

Phone _____ Date _____

PARENT/GUARDIAN AUTHORIZATION

1. I request that the above medication be given during school hours as ordered by this students' physician.
2. I release school personnel from any liability in relation to this request when the medication is given as ordered.
3. I will notify the school of any change in the medication (dosage change, medication being discontinued, etc.)
4. I give permission to the school nurse to communicate with 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.

Signature of Parent/Guardian _____ Date _____

**********EFFECTIVE FOR ONE (1) SCHOOL YEAR**********

Asthma Treatment Plan – Student

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

PACNJ Pediatric/Adult Asthma Coalition

Sponsored by American Lung Association in New Jersey

NJ Health New Jersey Department of Health

(Please Print)

Name	Date of Birth	Effective Date
Doctor Phone	Parent/Guardian (if applicable) Phone	Emergency Contact Phone

HEALTHY (Green Zone)

You have *all* of these:
- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work, exercise, and play

And/or Peak flow above _____

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

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

Remember to rinse your mouth after taking inhaled medicine.

If exercise triggers your asthma, take_____ ____ puff(s) ____minutes before exercise.

CAUTION (Yellow Zone)

You have *any* of these:
- Cough
- Mild wheeze
- Tight chest
- Coughing at night
- Other:_____

If quick-relief medicine does not help within 15-20 minutes or has been used more than 2 times and symptoms persist, call your doctor or go to the emergency room.

And/or Peak flow from_____ to_____

Continue daily control medicine(s) and ADD quick-relief medicine(s).

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	2 puffs every 4 hours as needed
☐ Xopenex®	2 puffs every 4 hours as needed
☐ Albuterol ☐ 1.25, ☐ 2.5 mg	1 unit nebulized every 4 hours as needed
☐ Duoneb®	1 unit nebulized every 4 hours as needed
☐ Xopenex® (Levalbuterol) ☐ 0.31, ☐ 0.63, ☐ 1.25 mg	1 unit nebulized every 4 hours as needed
☐ Combivent Respimat®	1 inhalation 4 times a day
☐ Increase the dose of, or add:	
☐ Other	

- **If quick-relief medicine is needed more than 2 times a week, except before exercise, then call your doctor.**

EMERGENCY (Red Zone)

Your asthma is getting worse fast:
- Quick-relief medicine did not help within 15-20 minutes
- Breathing is hard or fast
- Nose opens wide • Ribs show
- Trouble walking and talking
- Lips blue • Fingernails blue
- Other:_____

And/or Peak flow below _____

Take these medicines NOW and CALL 911.

Asthma can be a life-threatening illness. Do not wait!

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	4 puffs every 20 minutes
☐ Xopenex®	4 puffs every 20 minutes
☐ Albuterol ☐ 1.25, ☐ 2.5 mg	1 unit nebulized every 20 minutes
☐ Duoneb®	1 unit nebulized every 20 minutes
☐ Xopenex® (Levalbuterol) ☐ 0.31, ☐ 0.63, ☐ 1.25 mg	1 unit nebulized every 20 minutes
☐ Combivent Respimat®	1 inhalation 4 times a day
☐ Other	

Triggers

Check all items that trigger patient's asthma:

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

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

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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

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

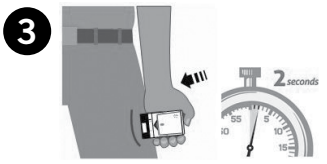
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

FARE
Food Allergy Research & Education

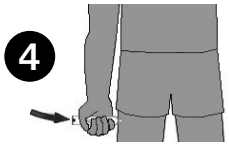
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

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



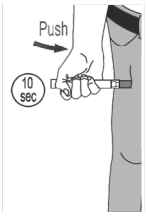
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

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

Paterson Charter School for Science 196
196 W. Railway Ave., Paterson, NJ 07503
Phone: (973) 247-0600 Fax: (973) 321-4254 Web: www.pcsst.org

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 a doctor's note 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 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: _____ Date of Birth: _____ Grade: _____

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

Symptoms include: _____

Epinephrine Brand & Dose:

_____

_____

Antihistamine (if any): _____

_____

_____

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 #:** _____
(Print)

I, parent/guardian of my above named student, authorize the emergency administration of epinephrine via a pre-filled, single dose 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.

Parent Signature: _____ **Parent Name**: _____
(Print)

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** _____