Newark Board of Education

Roger León, Superintendent

Where Passion Meets Progress

Physician's Request for Medication Administration in School

Student's Name: _____ Birth Date: _____

Address: _____ Grade:_____ Home Room:

Parent/Guardian: _____

Physician's Name: _____

Physician's Office Phone #: _____

I request that the following medication be administered by the school nurse, to the above mentioned student.

Diagnosis/Purpose: _____

Name of Medication: _____

Dosage: _____

Time of Circumstance under which medication shall be administered: _____

_____

Length of time medication indicated: _____

Possible Side Effects: _____

_____

_____

Special Instructions: _____

_____

_____

ADHD medication may be held if student will be attending field trip. Yes_____ No_____

Physician's Signature: _____ Date: _____

Newark Board of Education

Where Passion Meets Progress

Roger León
Superintendent

Child's Name _____ Date of Birth _____

Parent's Name _____ Phone Number_____

Specialist Name _____ Phone Number _____

ASTHMA QUESTIONNAIRE

PART ONE

At what age did your child first have their first asthma attack? _____

How often does your child have asthma attacks? _____

How many asthma attacks has your child had in last two years? _____
Has your child been hospitalized for asthma? □ Yes □ No If yes, how often? _____

When was your child's last hospitalization for asthma? _____

Has your child used asthma medicine in the past two years? □ Yes □ No If yes, how often? _____

Please list current Asthma medications below.

Medication	*Dosage*	*Frequency and time of Day taken*

- Has your child had an attack or recurrent attacks of wheezing? □ Yes □ No
- Does your child have a wheeze or cough after exercise? □ Yes □ No
- Does your child have wheeze, chest tightness, or cough after exposure to airborne allergens or pollutants? □ Yes □ No
- Does your child cough or wheeze more than a couple times a week □ Yes □ No
- Are symptoms improved by appropriate anti-asthma treatment? □ Yes □ No
- Does your child cough in their sleep more than a couple of times per month? □ Yes □ No
- Does your child miss school frequently due to asthma issues? □ Yes □ No

If your child requires asthma medication while in school, a written Asthma Action Plan is required from your child's doctor annually.
I understand that my child's asthma condition will be shared with school personnel on a need to know basis.

Parent/Guardian Signature_____ **Date**_____

Reviewing Nurse's Signature_____ **Date**_____

Asthma Action Plan Received; **Date**_____ **Comments**_____
Individual Healthcare Plan Completed; **Date**_____ **Comments**_____
Asthma Emergency Action Plan Completed: **Date** _____ **Comments**_____

Food Allergy Action Plan

Emergency Care Plan

Place Student's Picture Here

Name: _____ **D.O.B.:** ___/___/___

Allergy to: _____

Weight: _____ lbs. **Asthma:** ☐ Yes (higher risk for a severe reaction) ☐ No

Extremely reactive to the following foods: _____

THEREFORE:

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

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

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

LUNG:	Short of breath, wheeze, repetitive cough
HEART:	Pale, blue, faint, weak pulse, dizzy, confused
THROAT:	Tight, hoarse, trouble breathing/swallowing
MOUTH:	Obstructive swelling (tongue and/or lips)
SKIN:	Many hives over body

Or **combination** of symptoms from different body areas:

SKIN:	Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT:	Vomiting, diarrhea, crampy pain

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*
   -Antihistamine
   -Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

MILD SYMPTOMS ONLY:

MOUTH:	Itchy mouth
SKIN:	A few hives around mouth/face, mild itch
GUT:	Mild nausea/discomfort

1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring (see box below)

Medications/Doses

Epinephrine (brand and dose): _____

Antihistamine (brand and dose): _____

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

Monitoring

Stay with student; alert healthcare professionals and parent. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See back/attached for auto-injection technique.

_____ _____ _____ _____

Parent/Guardian Signature **Date** **Physician/Healthcare Provider Signature** **Date**

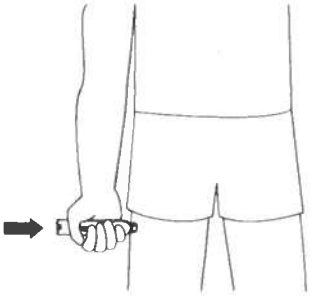
TURN FORM OVER

Form provided courtesy of the Food Allergy & Anaphylaxis Network (www.foodallergy.org) 9/2011

EpiPen Auto-Injector and EpiPen Jr Auto-Injector Directions

- First, remove the EpiPen Auto-Injector from the plastic carrying case
- Pull off the blue safety release cap

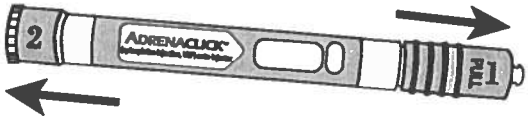
- Hold orange tip near outer thigh (always apply to thigh)



- Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 10 seconds. Remove the EpiPen Auto-Injector and massage the area for 10 more seconds

EpiPen 2-Pak® | EpiPen Jr 2-Pak®
(Epinephrine) Auto-Injectors 0.3/0.15mg

Adrenaclick™ 0.3 mg and Adrenaclick™ 0.15 mg Directions



Remove GREY caps labeled "1" and "2."

Place RED rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

A food allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student's physician, and a copy of this Food Allergy Action Plan.

A kit must accompany the student if he/she is off school grounds (i.e., field trip).

Contacts

Call 911 (Rescue squad: (___) _____-_____) Doctor: _____ Phone: (___) _____-_____

Parent/Guardian: _____ Phone: (___) _____-_____

Other Emergency Contacts

Name/Relationship: _____ Phone: (___) _____-_____

Name/Relationship: _____ Phone: (___) _____-_____

EPILEPSY FOUNDATION®
Not another moment lost to seizures

Seizure Action Plan

Effective Date

This student is being treated for a seizure disorder. The information below should assist you if a seizure occurs during school hours.

Student'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:

Student's response after a seizure:

Basic First Aid: Care & Comfort

Please describe basic first aid procedures:

Does student need to leave the classroom after a seizure? ❒ Yes ❒ No

If YES, describe process for returning student to classroom:

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
- Record seizure in log

For tonic-clonic seizure:

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

Emergency Response

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

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

- ❒ Contact school nurse at _____
- ❒ 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
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has a first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

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

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

Does student have a **Vagus Nerve Stimulator?** ❒ Yes ❒ No If YES, describe magnet use:

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

Describe any special considerations or precautions:

Physician Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____

DPC772

STUDENT SEIZURE QUESTIONNAIRE

SECTION 1 – CONTACT INFORMATION

Student Name: _____ DOB: _____

Building: _____ Grade: _____ Classroom: _____

Parent/Guardian Name: _____

Tel. (H): _____ (W): _____ (C): _____

Other Emergency Contact: _____

Tel. (H): _____ (W): _____ (C): _____

Child's Neurologist: _____ Tel: _____

Address: _____

Child's Primary Care Provider: _____ Tel: _____

Address: _____

What is the best way for us to communicate with you about your child's seizures? _____

Significant medial history or conditions: _____

SECTION 2 – SEIZURE INFORMATION

1. When was your child diagnosed with seizures or epilepsy? _____

2. Seizure Type(s)	Length	Frequency	Description

3. What might trigger a seizure in your child? _____

4. Are there any warning signs and/or behavior changes before the seizure occurs? ☐ Yes ☐ No If yes, please explain? _____

5. When was your child's last seizure? _____

6. Has there been any recent change in your child's seizure patterns? ☐ Yes ☐ No If yes, please explain: _____

7. How does your child react after a seizure? _____

8. Has child ever been hospitalized for continuous seizures? ☐ Yes ☐ No If yes, please explain: _____

9. How do other illnesses affect your child's seizure control? _____

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
- ✓ Record seizure in log

For tonic-clonic (grand mal) seizure:

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

10. What additional procedures should be taken when your child has a seizure in school?

_____

_____

_____

_____

_____

_____

A Seizure is generally considered an Emergency when:

- ✓ A convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- ✓ Student has repeated seizures without regaining consciousness
- ✓ Student has a first time seizure
- ✓ Student is injured or diabetic
- ✓ Student has breathing difficulties
- ✓ Student has a seizure in water

11. Please describe what constitutes an emergency for your child? (Answer may require consultation with treating physician and school nurse)

_____

_____

_____

_____

SECTION 3 - SEIZURE MEDICATION & TREATMENT INFORMATION

12. What daily medication(s) does your child take?

Medication Name:	Date Started	Dosage	Frequency & time of day taken	Possible side effects

13. What emergency/rescue medications are prescribed for your child?

Medication Name	Dosage	Administration Instructions* +	What to do after administration:**

**For example: After 2nd or 3rd seizure, for cluster seizures, etc. +Orally, under tongue, rectally, etc. **Call 911, call parent, etc.*

14. What daily medication(s) will your child need to take during school hours? _____

_____

15. Should any of these medications be administered in a special way? ☐ Yes ☐ No If yes, please explain:

_____

16. Should any particular reaction be watched for? ☐ Yes ☐ No If yes, please explain: _____

_____

17. Does your child have a Vagus Nerve Stimulator? ☐ Yes ☐ No If yes, please describe instructions for appropriate use of magnet: _____

_____

18. Will there be a back up magnet kept in school? ☐ Yes ☐ No If yes, location: _____

19. Will your child need to where a protective helmet in school? ☐ Yes ☐ No

SECTION 4 - SPECIAL CONSIDERATIONS

20. Check all that apply and describe any considerations or precautions that should be taken:

☐ General Health: _____	☐ Physical education/Sports: _____
☐ Physical Functioning: _____	☐ Recess: _____
☐ Learning: _____	☐ Bus Transportation: _____
☐ Behavior: _____	☐ Field Trips: _____
☐ Mood/Coping: _____	☐ Other: _____

Information necessary for the care of your child will be shared with appropriate school personnel including but not limited to: teachers, classroom aide, bus driver, playground personnel, and principal/administrator. Your signature gives us this consent.

Parent/Guardian Signature: _____ Date: _____

Dates Updated: _____, _____, _____

Please complete form and return to your child's school nurse.

Nurse: _____ Phone: _____ Fax: _____

Newark Board of Education

Roger León, Superintendent

Where Passion Meets Progress

PARENT MEDICATION CONSENT FORM

I hereby request and give permission to the school nurse to administer to my child:

NAME:_____ Birth Date:_____ Grade:____ Home Room:___

MEDICATION: _____

_____

_____

I give permission for the school nurse to contact the physician as deemed necessary. Additionally, I give permission for my child's picture to be taken and used for identification purposes during medication administration.

_____ _____

Signature of parent/guardian Date

Daytime phone numbers:_____

Address: _____

If I can not be reached, I designate

Name: _____

Address: _____

Daytime phone numbers: _____

as a responsible adult who would assume temporary responsibility in an emergency situation.

NOTE: If possible, parents are advised to give medication at home and on a schedule other than during school hours. If it is necessary that a medication be given during school hours, the following regulations must be followed:

- A written physician's order for the medication must be brought to the school nurse.
- The medication must be brought to school by the parent/guardian in the original container with the appropriate label attached. If medication is not properly labeled, it will NOT be given.
- The parent/guardian must sign this form, granting the school nurse permission to administer medication, according to regulations set herein.

Newark Board of Education

Roger León, Superintendent

Where Passion Meets Progress

Self Administration of Medication

WAIVER OF LIABILITY

As the parent(s) / guardian(s) of _____

I / we herewith request the Newark Public Schools permit our child to carry and use an inhaler, or epi pen, and/or one pre-measured dose of an anti-histamine while on school property or at an approved school event off school property. I / we agree to comply with the rules and regulations of the school district and hereby agree to Save and Hold Harmless the Newark Public Schools from and against any and all losses, claims, damages or expenses which may arise as a result of granting this request.

DATE:_____ SIGNED: _____

_____ _____

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	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.

REVISED MAY 2017

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

The Pediatric/Adult Asthma Coalition of New Jersey, sponsored by the American Lung Association in New Jersey. This publication was supported by a grant from the New Jersey Department of Health and Senior Services, with funds provided by the U.S. Centers for Disease Control and Prevention under Cooperative Agreement 5U59EH000491-5. Its content are solely the responsibility of the authors and do not necessarily represent the official views of the New Jersey Department of Health and Senior Services or the U.S. Centers for Disease Control and Prevention. Although this document has been funded wholly or in part by the United States Environmental Protection Agency under Agreement XA96296601-2 to the American Lung Association in New Jersey, it has not gone through the Agency's publications review process and therefore, may not necessarily reflect the views of the Agency and no official endorsement should be inferred. Information in this publication is not intended to diagnose health problems or take the place of medical advice. For asthma or any medical condition, seek medical advice from your child's or your health care professional.

Sponsored by

AMERICAN LUNG ASSOCIATION. IN NEW JERSEY