PARENTS MEDICAL CHECK LIST: Please Read Carefully!

School Nurses will be present at the respective schools to receive documentation starting from 5/4.
 All Medical Documents MUST be received by 6/16

Newark Tech Campus Ms. Cheryl Hamilton, RN, BS, CSN Donald M. Payne, Sr. Campus Ms. Dionne Pace, RN,BSN, CSN Ms. Amanda Gordon, RN West Caldwell Tech Campus Ms. Bonnie Rogers, RN, BSN, CSN

- PLEASE ENSURE ALL DOCUMENTS ARE COMPLETELY FILLED BY PARENT/GUARDIAN AND YOUR CHILD'S DOCTOR!Copy
 of Immunization and a completed Physical Form
- Don't wait; make appointments now with your Child's Doctor. Your Child will be excluded from school if his/her medical file is incomplete!
- Fill out forms completely and in PEN (not pencil)
- Make certain doctor <u>signs, stamps and dates</u> the physical form <u>before you leave his/her Office</u> (*Physicals are only effective for one (1) year from the date of the physical)
- Failure to provide a completed physical will result in exclusion from gym/sports/field trips. Exclusion from gym will negatively impact the student's overall grade. Copy of Immunization and a completed Physical Form
- Request that your child's 8th grade school send the student's original health record
- If your child wears eyeglasses or contacts, please visit eye doctor before school begins
- Remind your child that caring for their contacts is their responsibility (always carry a spare contact case and solution)
- If your child uses an *inhaler, your child's doctor will need to sign the Asthma Treatment Plan & you will need to sign the back of the form and provide a spare inhaler for the medical office; the inhaler MUST accompany your child on ALL field trips. If your child uses an *EpiPen, an Allergy Action Plan will need to be completed by your child's doctor & the EpiPen Must accompany your child on ALL field trips; a spare EpiPen pack should be provided to the medical office incomplete medical files will mean that your child will NOT be allowed to travel on Field Trips OR take Gym.
- Encourage your child to keep spare clothing on hand @ school in case of emergencies
- If your child suffers from menstrual cramps. Have her take pain medication <u>before</u> coming to school (or have the doctor complete the medication form provided in this packet and supply the medical office with the medication)- Students shouldn't miss class time before of menstrual cramps
- Remember to update the school nurses each time your child receives an immunization (booster shot)
- Always have someone available to pick your child up from school, should the need arise
- Medical notes excusing an absence need to be turned in the day the student returns to school
- Any assistive device (i.e. crutches, ankles brace, arm sling, etc) require a doctor's order/note
- If your child has a special diagnosis (high blood pressure, diabetes, etc) notify the medical office BEFORE SCHOOL STARTS
- Return all calls from the school nurses as soon as possible

To contact the child's school nurses, use email:

NT: CHamiton@essextech.org; PT: DPace@essextech.org OR AGordon@essesextech.org: WCT: BRogers@essextech.org



Essex County Vocational Technical Schools BOARD OF EDUCATION

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M. MURPHY DURKIN, ESQ BOARD ATTORNEY

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Previous School:	
School Doctor will be here on:	

NOTICE REGARDING PHYSICALS

Due to change in the New Jersey Administrative Code (N.J.A.C. 6A:16-22) "each student medical examination shall be conducted at the medical home (student's family physician or healthcare provider) of the student." For example, the student's physician or nurse practitioner/clinical nurse specialist may be acceptable.

If a student does not have a medical home (doctor), the school physician will perform the student medical examination in a district school health office, after the parent/guardian signs the form that they do not have a family physician or healthcare provider.

Student's Na	me (Print Name)		Grade/ID Number	er		
(check one) 	-		physician or health care provider. nd will need a physical exam from the di	istrict.		
(check one)						
	does your child hav	ve health insurance.				
if not, would you be interested in having New Jersey State insurance plan?			g the school nurse provide information regarding the			
		Parent/Guardian Sign	nature			
		Date	_			

ATTENTION PARENT/GUARDIAN: The preparticipation physical examination (page 3) must be completed by a health care provider who has completed the Student-Athlete Cardiac Assessment Professional Development Module.

■ PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keepa copy of this form in the chart.) Date of Exam _ Name _ Date of birth Sex ____ __ Age __ ____ Grade _ School Sport(s) Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below. ☐ Stinging Insects Explain "Yes" answers below. Circle questions you don't know the answers to. MEDICAL QUESTIONS No **GENERAL QUESTIONS** No Yes 26. Do you cough, wheeze, or have difficulty breathing during or 1. Has a doctor ever denied or restricted your participation in sports for after exercise? 27. Have you ever used an inhaler or taken asthma medicine? 2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections 28. Is there anyone in your family who has asthma? 29. Were you born without or are you missing a kidney, an eye, a testicle 3. Have you ever spent the night in the hospital? (males), your spleen, or any other organ? 4. Have you ever had surgery? 30. Do you have groin pain or a painful bulge or hernia in the groin area? **HEART HEALTH QUESTIONS ABOUT YOU** Yes No 31. Have you had infectious mononucleosis (mono) within the last month? 5. Have you ever passed out or nearly passed out DURING or 32. Do you have any rashes, pressure sores, or other skin problems? 33. Have you had a herpes or MRSA skin infection? 6. Have you ever had discomfort, pain, tightness, or pressure in your 34. Have you ever had a head injury or concussion? chest during exercise? 35. Have you ever had a hit or blow to the head that caused confusion, 7. Does your heart ever race or skip beats (irregular beats) during exercise? prolonged headache, or memory problems? 8. Has a doctor ever told you that you have any heart problems? If so, 36. Do you have a history of seizure disorder? check all that apply: 37. Do you have headaches with exercise? ☐ High blood pressure ☐ A heart murmur 38. Have you ever had numbness, tingling, or weakness in your arms or ☐ High cholesterol ☐ A heart infection legs after being hit or falling? ☐ Kawasaki disease Other: 39. Have you ever been unable to move your arms or legs after being hit 9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram) 40. Have you ever become ill while exercising in the heat? 10. Do you get lightheaded or feel more short of breath than expected during exercise? 41. Do you get frequent muscle cramps when exercising? 11. Have you ever had an unexplained seizure? 42. Do you or someone in your family have sickle cell trait or disease? 12. Do you get more tired or short of breath more quickly than your friends 43. Have you had any problems with your eyes or vision? during exercise? 44. Have you had any eye injuries? **HEART HEALTH QUESTIONS ABOUT YOUR FAMILY** Yes No 45. Do you wear glasses or contact lenses? 13. Has any family member or relative died of heart problems or had an 46. Do you wear protective eyewear, such as goggles or a face shield? unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)? 47. Do you worry about your weight? 48. Are you trying to or has anyone recommended that you gain or 14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan lose weight? syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic 49. Are you on a special diet or do you avoid certain types of foods? polymorphic ventricular tachycardia? 50. Have you ever had an eating disorder? 15. Does anyone in your family have a heart problem, pacemaker, or 51. Do you have any concerns that you would like to discuss with a doctor? implanted defibrillator? **FEMALES ONLY** 16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning? 52. Have you ever had a menstrual period? **BONE AND JOINT QUESTIONS** 53. How old were you when you had your first menstrual period? Yes No 17. Have you ever had an injury to a bone, muscle, ligament, or tendon 54. How many periods have you had in the last 12 months? that caused you to miss a practice or a game? Explain "ves" answers here 18. Have you ever had any broken or fractured bones or dislocated joints? 19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches? 20. Have you ever had a stress fracture? 21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism) 22. Do you regularly use a brace, orthotics, or other assistive device? 23. Do you have a bone, muscle, or joint injury that bothers you? 24. Do any of your joints become painful, swollen, feel warm, or look red? 25. Do you have any history of juvenile arthritis or connective tissue disease? I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Signature of parent/guardian

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HEGSGS 9-2681/0410

NOTE: The preparticiaption physical examination must be conducted by a health care provider who 1) is a licensed physician, advanced practice nurse, or physician assistant; and 2) completed the Student-Athlete Cardiac Assessment Professional Development Module.

PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM

HEUSES New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

1. Consider Do y Do y Do y Hav Duri Do y Hav Av Duri Do y Hav Hav		estions on a out or und, hopeless, our home o cigarettes, a ays, did you to use any anabolic s any supple belt, use a t	er a lot of pr depressed, or residence chewing tob u use chewin other drugs teroids or us ements to be nelmet, and	essure? or anxious? ? acco, snuff, or d noco, snu or? sed any other pe dp you gain or k use condoms?	ff, or dip? erformance supplement? ose weight or improve your	performance?		
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	ours (auscultation	standing, su	ıpine, +/- Val	salva)				
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Abdome	n							
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Back						 		
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	nd/fingers							
Hip/thig	1							
Knee				· · · · · · · · · · · · · · · · · · ·				
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Function						<u> </u>		
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□ Not c	barad		***************************************					
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	*		auun					
	☐ For any s	•						•
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Recomm	endations							
participa arise atte	te in the sport(s) as outline s been clear	d above. A (red for partic	opy of the phys	ical exam is on record in m	y office and can be n	nade available to t	t apparent clinical contraindications to practice ar the school at the request of the parents. If condition the potential consequences are completely explains
Name o								Date of exam
	s							Phone
Signatu	re of physician, /	APN, PA _						
					•			
								Society for Sports Medicine, American Orthopaedic ducational purposes with acknowledgment.

■ PREPARTICIPATION PHYSICAL EVALUATION CLEARANCE FORM

Name		Sex 🗆 M 🗇 F Age	Date of birth
☐ Cleared for	r all sports without restriction		
☐ Cleared for	r all sports without restriction with recommenda	ations for further evaluation or treatment for	
	,		
☐ Not cleare	d		• ,
	Pending further evaluation		
	For any sports		
Recommenda			
	,		
	YOV INTORINATION		
	ICY INFORMATION		
Allergies			
-			
	· · · · · · · · · · · · · · · · · · ·		
·			
Other informa	ttion		
-	1773 HILL TO THE		
HCP OFFICE	STAMP	SCHOOL PHYSICIAN:	
		Reviewed on	
		Approved Not	(Date) Approved
			•
	•	Signature:	
I have exar	nined the above-named student and co	mpleted the preparticipation physical evaluation.	The athlete does not present apparent
clinical cor	ntraindications to practice and participa	ite in the sport(s) as outlined above. A copy of the	physical exam is on record in my office
		west of the parents. If conditions arise after the a problem is resolved and the potential consequency	
	ts/guardians).	proment is resolved and the potential consequent	ies are completely explained to the aune
Name of phy	ysician, advanced practice nurse (APN), phys	sician assistant (PA)	Date
Address			Phone
	Cardiac Assessment Professional Developme		
Date	Signature		
~~·~	Oignaturo		

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New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

PERMISSION FOR ADMINISTRATION OF MEDICATION BY SCHOOL NURSE

NO MEDICATIONS ARE TO BE BROUGHT INTO SCHOOL WITHOUT SUBMITTING THIS FORM.
FORM MUST BE SIGNED BY YOUR CHILD'S DOCTOR.

MEDICATION DISPENSING FORM-PARENT/GUARDIAN

I reque I give	est that the enclo	osed medication, in	the original con	tainer, be administere	ed to	(student's name)
Name and Strengt	h of Medicatio	n				
Time of Adminis	tration	Do	sage	Prescription	Non-Prescription	_
Reason for Medic	ation					_
Effective dates: fr	om		20 to		20	
Parent/Guardian S	Signature	Date	Home Tele	phone	Work Telephone	
		PHYSICIAN				
Patient's Name						
Medication: Name	e, Strength, Dos	age, Time of Admi	nistration:			
Purpose of Medic	ation:					
Physician's Name	(Physici	an's Signature		
Physician's Stamp	(should includ	e address and phon	e#) Date		- 9	
***************************************		ELF-ADMII	NISTRATI	ON OF MEDI	CATION BY STUDENTS	SLISTED
<u>BEI</u> PHYSICIAN		FOR EMERG	ENCY/SEL	F-ADMINISTI	ERED MEDICATION	
school	nurse wheneve	r possible. In the ca	ise of an emerge	ency, or if the school r	name) be permitted to carry and admin _(diagnosis). This should be done unde nurse is not in the building, I have instruadminister the medication.	nister the following or the supervision of the acted this patient in the
Medication dosag	e and time of ac	lministration:				 -
Physician's name			Physic	ian's Signature		
Physician's Stamp	should includ	e address and phon	e#) Date			
Date rec'd (office	use)					

ATHLETIC SPORTS SIGN-OFF

Please Complete & Return to the Medical Office

Student's Previous School	300 8	
Student's Name		
Address		
City/State/Zip		
Home Phone #		
(1) Parent/Guardian's Nan	me	(Relation)
Phone #		
(2) Parent/Guardian's Nat	me	(Relation)
Phone #		
Please provide Email where you can i	receive notifications:	
Circle a	any sport(s) your child might be inte	erested in:
Girls' Soccer / Boys' Soccer / Cross	Country / Girls' Volleyball / Boys'	Volleyball / Girls' Basketball / Boys'
Basketball / Softb	oall / Baseball/ Track & Field / Chee	erleading / Bowling
Give	bottom portion to 8th grade school	nurse
Please ask that your child's 8th grade scho	ool nurse send the student's original he	alth record to the High School nurses @:
Essex County Schools of Technology	Essex County Schools of Technology	Essex County Schools of Technology
Donald M. Payne, Sr. Campus	Newark Tech Campus	West Caldwell Tech Campus
498-544 W. Market St.	91 W. Market St.	620 Passaic Ave
Newark, NJ 07107	Newark, NJ 07107	West Caldwell, NJ 07006
ATTENTION: Medical Office	ATTENTION: Medical Office	ATTENTION: Medical Office
Dear School Nurse:		
		ent's name (please print)] will be
attending	Campus for the 20/20	school year. At the end of the
		1 1 1 1 1 1 1 1
current school year. Please send the	original A45/immunization/medica	il record to the above address.

Asthma Treatment Plan – Student

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







(Please Print)

(Please Pri	nt)					
Name		-	1	Date of Birth	Effective Date	
Doctor			Parent/Guardian (if appli	cable)	Emergency Contact	
Phone			Phone		Phone	
HEALTHY	(Green Zone)	Tak	e daily control me re effective with a	dicine(s). Some "spacer" – use i	inhalers may be f directed.	Triggers Check all items
	You have all of these:	MEDIC	INF	HOW MUCH to take an	d HOW OFTEN to take it	that trigger patient's asthma:
700	 Breathing is good 	□ Δdva	ir® HEA □ 45 □ 115 □ 230	2 nuffs tw	vice a day	NAME OF THE OWNERS
(5)	 No cough or wheeze 	☐ Aero	span TM		puffs twice a day	☐ Colds/flu☐ Exercise
The state of the s	 Sleep through 	☐ Alves	sco® 🗆 80, 🗆 160		puffs twice a day	☐ Allergens
	the night	☐ Dule	ra® 🔲 100, 🔲 200	2 puffs tw	vice a day	O Dust Mites,
DET H	 Can work, exercise, 	☐ Ovar	ent© [] 44, [] 110, [] 220 ® [] 40, [] 80		nuffs twice a day	dust, stuffed
150	and play	Svm	bicort® □ 80. □ 160		puffs twice a day	animals, carpet
		☐ Adva	[®] □ 40, □ 80	5001 inhalatio	on twice a day	 Pollen - trees, grass, weeds
		☐ Asma	anex® Twisthaler® 🗌 110, 🔲 2	220	inhalations ☐ once ☐ twice a day on twice a day	o Mold
		Flove	ent® Diskus® 🔲 50 🔲 100 🔲	2501 inhalatio	on twice a day	o Pets - animal
		☐ Pulm	icort Respules® (Budesonide) 🗌 0.2	D	inhalations once twice a day	dander
		Sing	ulair® (Montelukast) 🗌 4, 🔲 5, [10 mg 1 tablet da	aily	 Pests - rodents, cockroaches
		☐ Othe	r		-	Odors (Irritants)
And/or Peak	flow above	☐ None)	8		o Cigarette smoke
			Remember t	to rinse your mouth at	fter taking inhaled medicine.	& second hand smoke
	If exercise triggers yo	ur asthm	na, take	puff(s) _	minutes before exercise.	
-						cleaning
CAUTION	(Yellow Zone)	Con	tinue daily control me	dicine(s) and ADD q	uick-relief medicine(s).	products, scented
	You have <u>any</u> of these:	MEDIC	CINE	HOW MUCH to take an	d HOW OFTEN to take it	products Smoke from
(-3. B	• Cough	-	terol MDI (Pro-air® or Proven			burning wood,
(e)	Mild wheeze		enex®			inside or outside
85 63	Tight chest				nebulized every 4 hours as needed	□ Weather
6	Coughing at night		neb®		nebulized every 4 hours as needed	 Sudden temperature
COL	• Other:				nebulized every 4 hours as needed	change
VW			bivent Respimat®			o Extreme weather
	edicine does not help within		ease the dose of, or add:			 hot and cold Ozone alert days
	or has been used more than	☐ Othe				Foods:
	nptoms persist, call your the emergency room.		uick-relief medicir	ne is needed mo	re than 2 times a	0
And/or Peak fl			ek, except before			0
						·
EMERGEI	ICY (Red Zone)	Ta	ake these med	dicines NOW	and CALL 911.	☐ Other:
Cartil	Your asthma is	As	thma can be a life	-threatening illn	ess. Do not wait!	0
3	getting worse fast:		DICINE		ake and HOW OFTEN to take it	0
1	Quick-relief medicine did		Albuterol MDI (Pro-air® or Pro		4 puffs every 20 minutes	0
	not help within 15-20 minu Breathing is hard or fast		/ananau@		4 puffs every 20 minutes	This asthma treatment
AUD D	Nose opens wide • Ribs sh	$_{\text{ow}} \mid \Box \stackrel{\cdot}{\vdash}$	Ropenex® Albuterol □ 1.25, □ 2.5 mg _		1 unit nebulized every 20 minutes	plan is meant to assist,
	 Trouble walking and talking 	ig 🗆 [Duoneb®	·	1 unit nebulized every 20 minutes	not replace, the clinical
And/or	• Lips blue • Fingernails blu	e . □ >	Kopenex® (Levalbuterol) □ 0.31,		1 unit nebulized every 20 minutes	decision-making
Peak flow	Other:				1 inhalation 4 times a day	required to meet individual patient needs
below			Other			Individual patient needs
	ishma Tradhest Flan et il s control si dipurioso fisi. The content is Resolution of the TCA-Richie (REAN-A) the PediatricaRAII Anthra autrelies, somes or inclied, stockory or medica, includin; but not		W - I - I - I - NA - II - II	DUNGO DIANGATURA DISTUR		DATE
Entertaine imples invaries or not enable, or ALAMA main nompresentation invariants ab criter, ALAMA maiss now my representations	out the war, may, reflectify, completioners, currency, or firmeliness or the		elf-administer Medication:	PHYSICIAN/APN/PA SIGNATI	UREPhysician's Orders	DATE
death can be to mated in nament shall ALAV-A compacted durings, personal injusticity to de- meding from forument instally to use the protection	re fairle for any duringers (including ne thou film office, in click told and film film of the charges equal for four or business in emption) if this Actions Trainer's Planning there based on secretary, contrary, but or		capable and has been instructed ethod of self-administering of the		rilysicialis utueis	Save
rychi kalitoy otwiele o d.A.M.A. otlicki rydin sistem a sellypos Toda otki dia sellypos	ethind of the pool, if yether demands AUM A million of Library or missed to Active Teamers Plan and It is not ble. **DOT** **TOTAL Control of the Active Teamers Team		nhaled medications named above	PARENT/GUARDIAN SIGNAT	URE	

REVISED AUGUST 2014
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in accordance with NJ Law.

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

PHYSICIAN STAMP

Print Medicines Only

Print

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.

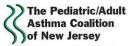
- 1. Parents/Guardians: Before taking this form to your Health Care Provider, complete the top left section with:
 - Child's name
- · Child's doctor's name & phone number
- · Parent/Guardian's name

- · Child's date of birth
- An Emergency Contact person's name & phone number
- & phone number



- 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
 - <u>Permission to Self-administer Medication</u> 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



Disclaimers: The use of this Website/PACNJ Ashma Treatment Plan and its content is at your own risk. The content is provided on an "as is" basis, The American Lung Association of the Mid-Allantic (ALAM-A), the Pediatric/Adult Ashma Coalition of New Jersey and all affiliates is cisclem all varranties, express or implied, studyor or or drivers, inclusing but not limited to the implied varranties or merchantability, non-intengenent of third parties' rights, and fitness for a particular purpose. ALAM-A makes no rerepresentations or versariates about the accuracy, reliability, completeness, currency, or timeliness of the content. ALAM-A makes no versariate, representation or or quarranty that their formation will be unfratmyted or error free or that any defects can be corrected. In no event shall ALAM-A be liable for any damages, inclination, incidental and consequential damages, personal injury/woronglul death, logs profits or damages resulting from daze or business intemption) resulting from the sure or busing from the sure or busing from the sure or inability to use the content of this Adamna Tearment Plan whether breast or overantly, correct, dot or any ord her legal theory, and whether or not ALAM-A is advised of the possibility of such damages, ALAM-A and its affiliates are not habit for any claim, whatsoever, caused by your use or misuse of the Asthma Tearment Plan. In or of this website.

AMERICAN LUNG ASSOCIATION. IN NEW JERSEY

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FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name:	
Allergy to:	PICTURE HERE
Weight: Ibs. Asthma: Yes (higher risk for	
NOTE: Do not depend on antihistamines or inhalers (t	oronchodilators) to treat a severe reaction. USE EPINEPHRINE.
Extremely reactive to the following allergens:	
THEREFORE:	
If checked, give epinephrine immediately if the allergen	
If checked, give epinephrine immediately if the allergen	was DEFINITELY eaten, even if no symptoms are apparent.
FOR ANY OF THE FOLLOWING:	MILD CVMDTOMC
SEVERE SYMPTOMS	MILD SYMPTOMS
(A) (4) (5) (<	
	NOSE MOUTH SKIN GUT
	IUTH Itchy or Itchy mouth A few hives, Mild itch nausea or
	ng of the sneezing discomfort
repetitive cough weak pulse, breathing or tongu dizziness swallowing	e or lips FOR MILD SYMPTOMS FROM MORE THAN ONE
UIZZINESS SWAIIOWING	SYSTEM AREA, GIVE EPINEPHRINE.
	DRA
•	FOR MILD SYMPTOMS FROM A SINGLE SYSTEM
	mptoms AREA, FOLLOW THE DIRECTIONS BELOW:
I many mice over moperation reaming	y areas. 1. Antihistamines may be given, if ordered by a healthcare provider.
redness diarrhea about to happen,	2. Stay with the person; alert emergency contacts.
anxiety, confusion	3. Watch closely for changes. If symptoms worsen,
1. INJECT EPINEPHRINE IMMEDIATELY	give epinephrine.
2. Call 911. Tell emergency dispatcher the person is havi	ng
anaphylaxis and may need epinephrine when emergency	MEDICATIONS/DOSES
responders arrive.	Epinephrine Brand or Generic:
 Consider giving additional medications following epinept » Antihistamine 	
» Inhaler (bronchodilator) if wheezing	Epinephrine Dose: 0.15 mg IM 0.3 mg IM
Lay the person flat, raise legs and keep warm. If breathir	
difficult or they are vomiting, let them sit up or lie on the	Antihistamina Daga
 If symptoms do not improve, or symptoms return, more dos epinephrine can be given about 5 minutes or more after the 	es of the last dose.
Alert emergency contacts.	Other (e.g., inhaler-bronchodilator if wheezing):

Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.



FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

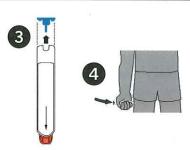
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

- 1. Remove Auvi-Q from the outer case.
- 2. Pull off red safety guard.
- 3. Place black end of Auvi-Q against the middle of the outer thigh.
- 4. Press firmly, and hold in place for 5 seconds.
- 5. Call 911 and get emergency medical help right away.

55 Seconds 10 15

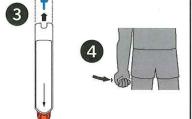
HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR, MYLAN

- 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.
- 3. With your other hand, remove the blue safety release by pulling straight up.
- 4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
- 5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
- 6. Remove and massage the injection area for 10 seconds.
- 7. Call 911 and get emergency medical help right away.



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

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



HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, IMPAX LABORATORIES

- 1. Remove epinephrine auto-injector from its protective carrying case.
- 2. Pull off both blue end caps: you will now see a red tip.
- 3. Grasp the auto-injector in your fist with the red tip pointing downward.
- 4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
- 5. Press down hard and hold firmly against the thigh for approximately 10 seconds,
- 6. Remove and massage the area for 10 seconds.
- 7. Call 911 and get emergency medical help right away.

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

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP:

RESCUE SQUAD:		NAME/RELATIONSHIP:
DOCTOR:	PHONE:	PHONE:
PARENT/GUARDIAN:	PHONE:	NAME/RELATIONSHIP:
		DUONE

SCHOOL SEIZURE ACTION PLAN FOR

Attach Student Photo

(INSERT NAME HERE)

ABOUT

Name			9		Date of Birt	h
Doctors Name	*			ā	Phone	
Emergency Contact Name					Phone	
Emergency Contact Name			3 0		Phone	
Seizure Type/Name:						
What Happens:						
How Long It Lasts:		-				
How Often:			in ea			
	sical Stress		nts	□ Illness with	Cycle n high fever necify:	3
DAILY TREATMENT PLAN Seizure Medicine(s)	1					
Name	Ho	w Much		How Ofte	en/When	表示更示规
		ùr.				
						*1
		Ψ.		14		
Additional Treatment/Care: (i.e.:	diet, sleep, d	evices etc.)				
CAUTION-STEP UP Symptoms that signal a			additional	treatment r	nay be nee	ded:
□ Headache □ Staring		□ Confusion	□ Dizz		□ Chan	ge in Vision/Auras
□ Sudden Feeling of Fear or Anxiet	ty	□ Other Specify: _				
Additional Treatment: Continue Daily Treatment Plan If missed medicine, give prescuence Do not give a double dose or g					= 4	
□ Change to:	How	/ Much:		How Often	/When:	
□ Add:	How	Much:		How Often	/When:	
Other Treatments / Care: /i.e.: elec	on doviced:					

SCHOOL SEIZURE ACTION PLAN

DANGER-GET HELP NOW Follow Seizure First Aid Below □ Contact School Nurse or Adult trained on rescue medication: Number: □ Record Duration and time of each seizure(s) □ Call 911 if: • Student has a convulsive seizures lasting more than ___minutes Student is injured or has diabetes • Student has repeated seizures without regaining consciousness · Student is having breathing difficulty When EMS arrives, a medical provider will perform an individual assessment to determine appropriate next steps. Rescue Therapy: □ Rescue therapy provided according to physician's order: **POST SEIZURE RECOVERY** Typical Behaviors/Needs After Seizure: □ Headache □ Drowsiness/Sleep □ Nausea Aggression □ Confusion/Wandering □ Blank Staring Other Specify:_ Reviewed/Approved by: Physician Signature Date Parent/Guardian Signature Date **SEIZURE FIRST AID** Observe and Record What Happens As Seizure Ends, Offer Help

Image adapted with permission from the Epilepsy Foundation of America

Stay Calm Don't Hold Down

Cushion Head, Remove Glasses

LEARN MORE AND GET A DOWNLOADABLE VERSION OF THIS ACTION PLAN AT:







Don't Put Anything in the Person's Mouth, Turn on Their Side

Loosen Tight Clothing