Date: __________________

Dear Parent/Guardian:

Marion P. Thomas Charter School requires a complete physical every year for all students. Students in grades K-5 will complete the Universal Child Health form any other form in the packet that applies to them (ex: Food Allergy Action Plan, Asthma Treatment Plan, Seizure Action Plan, Allergies/Anaphylaxis, OTC Medication Authorization Form, Allergies/ Home Medications/In School Medications, Authorization for Exchange of Confidential Information, Request for Emergency Information). Sign and note N/A if form does not apply to your child but return as proof that you received the information.

Students in grades 6-12 will complete the Pre-participation Physical Evaluation form, even if they do not plan to participate in sports activities. It is a better assessment tool for students in this age group. Please complete any form in the packet that applies to your child, as listed above in 2nd paragraph. Sign and note N/A if form does not apply to your child but return as proof that you received the information.

- NO STUDENT WILL BE ALLOWED TO START THE SCHOOL YEAR WITHOUT A CURRENT PHYSICAL ON FILE. PHYSICALS ARE DUE AUGUST.

We aim to keep our scholars healthy and in school. Please contact the nurse at your child's campus with any questions you have.
**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 keep copy of this form in the chart.)

Date of Exam

Name

Sex

Age

Grade

School

Sport(s)

Date of birth

School

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.

☐ Medicines  ☐ Pollens  ☐ Food  ☐ Stinging Insects

Explain “Yes” answers below. Circle questions you don’t know the answers to.

<table>
<thead>
<tr>
<th>GENERAL QUESTIONS</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Has a doctor ever denied or restricted your participation in sports for any reason?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other:</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>3. Have you ever spent the night in the hospital?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>4. Have you ever had surgery?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>5. Have you ever passed out or nearly passed out during exercise or after exercise?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>7. Does your heart ever race or skip beats (irregular beats) during exercise?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other:</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>9. Has a doctor ever ordered a test for your heart? (For example, ECG, ECHO, echocardiogram)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>10. Do you get lightheaded or feel short of breath than expected during exercise?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>11. Have you ever had an unexplained seizure?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>12. Do you get more tired or short of breath more quickly than your friends during exercise?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (excluding drowning, unexplained car accident, or sudden infant death syndrome)?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>14. Does anyone in your family have hypertrrophic cardiomyopathy, Marfan syndrome, amyloidosis, right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, sickle cell disease, or calcium channel polymorphic ventricular tachycardia?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MEDICAL QUESTIONS</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>26. Do you cough, sneeze, or have difficulty breathing during or after exercise?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>27. Have you ever used an inhaler or taken asthma medicine?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>28. Is there anyone in your family who has asthma?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>29. Were you born without or are you missing a kidney, an eye, a testicle (male, your spine, or any other organ?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>30. Have you ever had groin pain or a painful bulge or hernia in the groin area?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>31. Have you had infectious mononucleosis (gland) within the past month?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>32. Do you have any rashes, pressure sores, or other skin problems?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>33. Have you had a herpes or MRSA skin infection?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>34. Have you ever had a head injury or concussion?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>36. Do you have a history of seizure disorder?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>37. Do you have headaches with exercise?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>39. Have you ever been unable to move your arms or legs after being hit or falling?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>40. Have you ever become ill while exercising in the heat?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>41. Do you get frequent muscle cramps while exercising?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>42. Do you or someone in your family have sickle cell trait or disease?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>43. Have you had any problems with your eyes or vision?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>44. Have you had any eye injuries?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>45. Do you wear glasses or contact lenses?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>46. Do you wear protective eyewear, such as goggles or a face shield?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>47. Do you worry about your weight?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>48. Are you trying to or have anyone recommended that you gain or lose weight?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>49. Are you on a special diet or do you avoid certain types of foods?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>50. Have you ever had an eating disorder?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>51. Do you have any concerns that would like to discuss with a doctor?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FEMALES ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>52. Have you ever had a menstrual period?</td>
</tr>
<tr>
<td>53. How old were you when you had your first menstrual period?</td>
</tr>
<tr>
<td>54. How many periods have you had in the last 12 months?</td>
</tr>
</tbody>
</table>

Explain "yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Athlete

Signature of Parent/Guardian

Date

©2017 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Association for Sports Medicine, and American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted to reprint for noncommercial, educational purposes with acknowledgment.
### Preparticipation Physical Evaluation: The Athlete with Special Needs: Supplemental History Form

<table>
<thead>
<tr>
<th>Date of Exam</th>
<th>Name</th>
<th>Date of birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sex</th>
<th>Age</th>
<th>Grade</th>
<th>School</th>
<th>Sport(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### 1. Type of disability

#### 2. Date of disability

#### 3. Classification (if available)

#### 4. Cause of disability (birth, disease, accident/trauma, other)

#### 5. List the sports you are interested in playing

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### 6. Do you regularly use a brace, assistive device, or prosthesis?

#### 7. Do you use any special bracing or assistive devices for sports?

#### 8. Do you have any rashes, pressure sores, or any other skin problems?

#### 9. Do you have a hearing loss? Do you use a hearing aid?

#### 10. Do you have a visual impairment?

#### 11. Do you use any special devices for bowel or bladder function?

#### 12. Do you have burning or discomfort when urinating?

#### 13. Have you had autonomic dysreflexia?

#### 14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?

#### 15. Do you have muscle spasticity?

#### 16. Do you have frequent seizures that cannot be controlled by medication?

Explain "yes" answers here

---

Please indicate if you have ever had any of the following:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atlantoaxial instability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X-ray evaluation for atlantoaxial instability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dislocated joints (more than one)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Easy bleeding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enlarged spleen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Osteopenia or osteoporosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty controlling bowel</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty controlling bladder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Numbness or tingling in arms or hands</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Numbness or tingling in legs or feet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weakness in arms or hands</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weakness in legs or feet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recent change in coordination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recent change in ability to walk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spina bifida</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Latex allergy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Explain "yes" answers here

---

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete ___________________________ Signature of parent/guardian ___________________________ Date ____________


New Jersey Department of Education 2014, Pursuant to P.L.2013, c.71
PREPARTICIPATION PHYSICAL EVALUATION
PHYSICAL EXAMINATION FORM

Name ___________________________ Date of birth ___________________________

PHYSICIAN REMINDERS
1. Consider additional questions on more sensitive issues
   * Do you feel stressed out or under a lot of pressure?
   * Do you ever feel sad, hopeless, depressed, or amnesic?
   * Do you feel safe at your home or residence?
   * Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   * During the past 30 days, did you use smoking tobacco, snuff, or dip?
   * Do you drink alcohol or use any other drugs?
   * Have you ever taken anabolic steroids or used any other performance supplement?
   * Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   * Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 6–14).

EXAMINATION
Height ___________________________ Weight ___________________________

Male □ Female □

BP / / Pulse Vision P 20 L 20/ Corrected □ Y □ N

MEDICAL

Appearance
   * Marfan stigmata (hyphema, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperflexy, myopia, MVP, aortic insufficiency)

Eyes/ears/nose/throat
   * Pupils equal
   * Hearing

Lymph nodes

Heart
   * Murmurs (auscultation standing, supine, 4-L, Valsalva)
   * Location of point of maximal impulse (PIM)

Pulses
   * Simultaneous femoral and radial pulses

Lungs

Abdomen

Genitourinary (males only) a

Steth.
   * HIV lesions suggestive of MRSA, linea corporis

Neurologic a

MUSCULOSKELETAL

Neck

Back

Shoulder/arm

Elbow/forearm

Wrist/hand/fingers

Hip/leg

Knee

Legs/ankle

Feet

Functional
   * Duck-walk, single leg hop

*Consider ECG, echocardiogram, and refer to cardiologist for abnormal cardiac history or exam.
*Consider (4) exam if in private setting. Having third party present is recommended.
*Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction
☐ Cleared for all sports with restriction with recommendations for further evaluation or treatment for ___________________________

☐ Not cleared
   ■ Pending further evaluation
   ■ For any sports
   ■ For certain sports
   ■ Reason ___________________________

Recommendations ___________________________

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parent. If conditions arise after the athlete has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parent/guardian).

Name of physician, advanced practice nurse (APN), physician assistant (PA) (print/type) ___________________________
Address ___________________________
Phone ___________________________

Signature of physician, APN, PA ___________________________

PREPARTICIPATION PHYSICAL EVALUATION
CLEARANCE FORM

Name ________________________________ Sex □ M □ F Age __________ Date of birth __________

☐ Cleared for all sports without restriction
☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for ____________________________________________

☐ Not cleared
☐ Pending further evaluation
☐ For any sports
☐ For certain sports ____________________________________________
Reason

Recommendations ____________________________________________

EMERGENCY INFORMATION
Allergies ______________________________

Other information ____________________________________________

HCP OFFICE STAMP

SCHOOL PHYSICIAN:
Reviewed on ___________ (Date)
Approved _______ Not Approved _______
Signature: ____________________________________________

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) ______________________________ Date ___________
Address _______________________________________ Phone ___________
Signature of physician, APN, PA ____________________________________________

Completed Cardiac Assessment Professional Development Module
Date __________________________ Signature __________________________

Asthma Treatment Plan – Student

This asthma action plan meets NJ Law N.J.S.A. 18A:40-12(b) [Physician's Orders]

(Please Print)

Name: __________________________ Date of Birth: ____________ Effective Date: ____________

Doctor: __________________________ Parent/Guardian (if applicable): __________________________

Phone: __________________________ Emergency Contact: __________________________

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

<table>
<thead>
<tr>
<th>MEDICINE</th>
<th>HOW MUCH to take and HOW OFTEN to take it</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advair® HFA 45, 115, 230</td>
<td>2 puffs twice a day</td>
</tr>
<tr>
<td>Alvesco® 80, 160</td>
<td>1, 2 puffs twice a day</td>
</tr>
<tr>
<td>Duerla® 100, 200</td>
<td>2 puffs twice a day</td>
</tr>
<tr>
<td>Fostin® 44, 110, 220</td>
<td>2 puffs twice a day</td>
</tr>
<tr>
<td>Gua® 40, 80</td>
<td>1, 2 puffs twice a day</td>
</tr>
<tr>
<td>Symbicort® 80, 160</td>
<td>1, 2 puffs twice a day</td>
</tr>
<tr>
<td>Advair Diskus® 100, 250, 500</td>
<td>1 inhalation twice a day</td>
</tr>
<tr>
<td>Asmanex® Twisthaler® 110, 220</td>
<td>1, 2 inhalations once or twice a day</td>
</tr>
<tr>
<td>Fostin® Diskus® 50, 100, 250</td>
<td>1 inhalation twice a day</td>
</tr>
<tr>
<td>Pulmicort Flexhaler® 80, 160</td>
<td>1, 2 inhalations once or twice a day</td>
</tr>
<tr>
<td>Pulmicort Respules® (Budesonide) 0.25, 0.5, 1.0</td>
<td>1 unit nebulized once or twice a day</td>
</tr>
<tr>
<td>Singular® (Montelukast) 4, 5, 10 mg</td>
<td>1 tablet daily</td>
</tr>
</tbody>
</table>

Other: __________________________

And/or Peak flow above ________

If exercise triggers your asthma, take ________ puff(s) ________ minutes before exercise.

Remember to rinse your mouth after taking inhaled medicine.

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

<table>
<thead>
<tr>
<th>MEDICINE</th>
<th>HOW MUCH to take and HOW OFTEN to take it</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albuterol MDI (Pro-air® or Proventil® or Ventolin®)</td>
<td>2 puffs every 4 hours as needed</td>
</tr>
<tr>
<td>Xopenex®</td>
<td>2 puffs every 4 hours as needed</td>
</tr>
<tr>
<td>Albuterol 1.25, 2.5 mg</td>
<td>1 unit nebulized every 4 hours as needed</td>
</tr>
<tr>
<td>Duoneb®</td>
<td>1 unit nebulized every 4 hours as needed</td>
</tr>
<tr>
<td>Xopenex® (Levalbuterol) 0.31, 0.63, 1.25 mg</td>
<td>1 unit nebulized every 4 hours as needed</td>
</tr>
<tr>
<td>Combivent Respimat®</td>
<td>1 inhalation 4 times a day</td>
</tr>
</tbody>
</table>

Other: __________________________

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

<table>
<thead>
<tr>
<th>MEDICINE</th>
<th>HOW MUCH to take and HOW OFTEN to take it</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albuterol MDI (Pro-air® or Proventil® or Ventolin®)</td>
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</tr>
<tr>
<td>Combivent Respimat®</td>
<td>1 inhalation 4 times a day</td>
</tr>
</tbody>
</table>

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 inhaler medications named above in accordance with NJ Law.
□ This student is not approved to self-medicate.

Physician's Orders: __________________________

Parent/Guardian signature: __________________________

Physician Stamp: __________________________

Text added by Dr. Sheri Coonley – Paediatrics and Asthma, Respiratory Care. 2014. To reproduce this form visit www.pcasnj.org
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
   • Child's date of birth
   • 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 __________
# Allergies / Anaphylaxis

**Medication Administration Form - Office of School Health**

**Authorization for Administration of Medication to Students for School Year 2015-2016**

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student Last Name</td>
<td></td>
</tr>
<tr>
<td>Student First Name</td>
<td></td>
</tr>
<tr>
<td>Student Middle Name</td>
<td></td>
</tr>
<tr>
<td>Date of birth</td>
<td></td>
</tr>
<tr>
<td>Weight (kg)</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>Male/Female</td>
</tr>
<tr>
<td>OSIS #</td>
<td></td>
</tr>
<tr>
<td>DOE District</td>
<td></td>
</tr>
<tr>
<td>Grade</td>
<td></td>
</tr>
<tr>
<td>Class</td>
<td></td>
</tr>
<tr>
<td>School (include name, number, address and borough)</td>
<td></td>
</tr>
</tbody>
</table>

### The Following Section to be Completed by Student’s Health Care Provider

<table>
<thead>
<tr>
<th>Allergy</th>
<th>Specify Allergy</th>
<th>Allergy to</th>
<th>Specify Allergy</th>
<th>Specify Allergy</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of asthma</td>
<td>Yes (If yes, student has an increased risk for a severe reaction)</td>
<td>No</td>
<td>Self-Manage</td>
<td>Yes/No</td>
</tr>
<tr>
<td>History of anaphylaxis</td>
<td>Yes Date mm/dd/yyyy</td>
<td>No</td>
<td>Recognize signs of allergic reactions</td>
<td>Yes/No</td>
</tr>
</tbody>
</table>

### Treatment

<table>
<thead>
<tr>
<th>If yes, symptoms</th>
<th>Specify Allergy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory</td>
<td>Skin</td>
</tr>
<tr>
<td>Gl</td>
<td>Cardiovascular</td>
</tr>
<tr>
<td>Neurologic</td>
<td></td>
</tr>
</tbody>
</table>

### History of Skin Testing

<table>
<thead>
<tr>
<th>Specify Allergy</th>
<th>Date mm/dd/yyyy</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Select In School Medications

1. **Only Single Dose Auto-Injectors Select Below**
   - Epinephrine Auto-Injector 0.15 mg/0.3 ml
   - Epinephrine Auto-Injector 0.3 mg/0.3 ml
   - Give antihistamine in addition to epinephrine (must order antihistamine below)

### Choose all Options that are Appropriate

- Student may carry medication and may self-administer (Includes School Trips &/or After-School Programs) (Parent Must Initial Reverse Side)
- Medication should be kept in close proximity to student; choose option:
  - Student to self-administer (Parent Must Initial Reverse Side)
  - Nurse or trained staff to administer

2. **Oral Medication:**
   - Diphenhydramine
   - Preparation/Concentration: 
   - Route: 

### Choose all Options that are Appropriate

- Student may carry medication and may self-administer (Includes School Trips &/or After-School Programs) (Parent Must Initial Reverse Side)
- Medication should be kept in close proximity to student; choose option:
  - Student to self-administer (Parent Must Initial Reverse Side)
  - Nurse to administer

3. **Oral Medication:**
   - Preparation/Concentration: 
   - Route: 

### Choose all Options that are Appropriate

- Student may carry medication and may self-administer (Includes School Trips &/or After-School Programs) (Parent Must Initial Reverse Side)
- Medication should be kept in close proximity to student; choose option:
  - Student to self-administer (Parent Must Initial Reverse Side)
  - Nurse to administer

**In School Instructions**

### PRN (Check all that apply):

- Itching
- Shortness of Breath
- Vomiting / Diarrhea
- Hives
- Tightness / Closure
- Weak Pulse
- Swelling
- Hoarseness
- Pallor / Cyanosis
- Redness
- Wheezing
- Dizziness / Fainting

**Specify signs, symptoms, or situations:**

- Administer Intramuscularly into anterolateral aspect of thigh
- Call 911 immediately

If no improvement, repeat in ___ minutes for a maximum of ___ times (not to exceed a total of 3 doses).

### PRN (Check all that apply):

- Itchy / Runny
- Itchy Mouth
- Few Hives
- Mildly Itchy Skin
- Mild Nausea / Discomfort

**Specify signs, symptoms, or situations:**

**Dose:** __________ q 4 hours or __ 6 hours as needed (specify)

If no improvement, indicate instructions:

**PRN Specify signs, symptoms, or situations:**

**Dose:** __________ Time interval: q ___ (specify min or hours)

**Conditions under which medication should not be given:**

If no improvement, indicate instructions:

### Home Medications (Include Over-the-Counter)

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Route</th>
</tr>
</thead>
</table>

**For DOHMH Only**

| Revision per DOHMH after consultation with prescribing provider. | □ IEP |

**Health Care Practitioner (Please Print):**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Signature</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>Tél. (____) _______</th>
<th>Fax. (____) _______</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mail Address</td>
<td>Cell* (____) _______</td>
<td>Medicaid # _______</td>
</tr>
</tbody>
</table>

**Incomplete provider information will delay implementation of medication orders**

Confidential information should not be continued on this page.
ALLERGIES / ANAPHYLAXIS
MEDICATION ADMINISTRATION FORM - OFFICE OF SCHOOL HEALTH
Authorization for Administration of Medication to Students for School Year 2015-2016

Student Last Name       First Name               MI       Date of birth __/__/____     School

PARENT/GUARDIAN'S CONSENT AND AUTHORIZATION

I hereby authorize the storage and administration of medication, as well as the storage and use of necessary equipment to administer the medication, in accordance with the instructions of my child's physician. I understand that I must provide the school with the medication and equipment necessary to administer medication, including non-Ventolin inhalers. Medication is to be provided to a properly labeled original container from the pharmacy (another such container should be obtained by me for my child's use outside of school); the label on the prescription medication must include the name of the student, name and telephone number of the pharmacy, licensed prescriber's name, name and date of refills, name of medication, dosage, frequency of administration, route of administration and/or other directions; over the counter medications and drug samples must be in the manufacturer's original container, with the student's name affixed to that container. I understand that if I provide an asthma inhaler, it must be supplied in its original and UNOPENED medication box. I further understand that I must immediately advise the school nurse and the principal and/or his/her designee(s) of any change in the prescription or instructions stated above.

I understand that no student will be allowed to carry or self-administer controlled substances.

I understand that this Authorization is only valid until the earlier of: (1) June 30, 2016 (This prescription may be extended through August if the student is attending a New York City Department of Education ("DOE") sponsored summer instruction program); or (2) such time that I deliver to the school nurse and the principal and/or his/her designee(s) a new prescription or instructions issued by the child's physician regarding the administration of the above-prescribed medication. By submitting this MAF, I am requesting that my child be provided with specific health services by DOE and the New York City Department of Health and Mental Hygiene ("DOHMH") through the Office of School Health ("OHS"). I understand that part of these services may entail an assessment by OSH physician as to how my child is responding to the prescribed medication. Full and complete instructions regarding the provision of the above-requested health service(s) are included in this MAF. I understand that OSH and their agents, and employees involved in the provision of the above-requested health service(s) are relying on the accuracy of the information provided in this form. I am solely responsible for any adverse reaction to this medication.

I recognize that this form is not an agreement by OSH and DOE to provide the services requested, but rather my request, consent and authorization for such services. If it is determined that these services are necessary, a Student Accommodation Plan may also be necessary and will be completed by the school.

I hereby authorize OSH and DOE and their employees and agents, to contact, consult with and obtain any further information they may deem appropriate relating to my child's medical condition, medication and/or treatment, from any health care provider and/or pharmacist that has provided medical or health services to my child.

**SELF-ADMINISTRATION OF MEDICATION: Initial this paragraph for use of an epinephrine, asthma inhaler and other approved self-administered medications:**

I hereby certify that my child has been fully instructed and is capable of self-administration of the prescribed medication. I further authorize my child's carrying, storage and self-administration of the above-prescribed medication in school. I acknowledge that I am responsible for providing my child with such medication in containers labeled as described above, for any and all monitoring of my child's use of such medication, as well as for any and all consequences of my child's use of such medication in school. I further hereby authorize OSH and DOE, their agents and employees; including the school nurse, principal, his/her designee(s), and my child's teacher(s), to administer such medication in accordance with the instructions of my child's physician should my child be temporarily incapable of self-administering such medication. I understand that the school nurse will confirm my child's ability to self-carry and self-administer in a responsible manner. In addition, I agree to proceed with "back up" medication in a clearly labeled container to be kept in the medical room in the event my child does not have sufficient medication to self-administer.

I also authorize the principal, his/her designee(s) and school nurse to store and/or administer to my child such medication in the event that my child is temporarily incapable of self-storage and self-administration of such medication.

I hereby certify that I have consulted with my child's health care provider and that I authorize the Office of School Health to administer stock Ventolin in the event that my child's asthma prescription medication is unavailable.

You must send your child's epinephrine, asthma inhaler and other approved self-administered medications with your child on a school trip, day, and/or after-school programs in order that he/she has it available.

Parent/Guardian's Signature  Print Parent/Guardian's Name

Date Signed __/__/____

Parent/Guardian's Address

Telephone Numbers: Daytime (___) ___-____  Home (___) ___-____  Cell Phone (___) ___-____

Parent/Guardian e-mail address

Alternate Emergency Contact's Name  Contact Telephone Number (___) ___-____

DO NOT WRITE BELOW - FOR DOE AND DOHMH ONLY

Received by: Name Date __/__/____  Reviewed by: Name Date __/__/____

Self-Administrates/Self-Carries: ☐ Yes ☐ No Services provided by: ☐ Nurse ☐ DOHMH Public Health Advisor ☐ School Based Health Center ☐ DOE School Staff

Signature and Title (RN OR MD)
Name: ___________________________ D.O.B.: ___________________________

Allergy to: ___________________________

Weight: ___________________________ lbs. Asthma: [ ] Yes (higher risk for a severe reaction) [ ] No

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

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.

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.

FOR MILD SYMPTOMS FROM 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.

MILD SYMPTOMS

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/discomfort

MEDICATIONS/DOSES

Epinephrine Brand: ___________________________

Epinephrine Dose: [ ] 0.15 mg IM  [ ] 0.3 mg IM

Antihistamine Brand or Generic: ___________________________

Antihistamine Dose: ___________________________

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

PARENT/GUARDIAN AUTHORIZATION SIGNATURE ___________________________ DATE ___________________________

PHYSICIAN/HCP AUTHORIZATION SIGNATURE ___________________________ DATE ___________________________

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 5/2014
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS
1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.

AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS
1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.

ADRENACLICK®/ADRENACLICK® GENERIC 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 penetrates.
5. Hold for 10 seconds. Remove from thigh.

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 get worse quickly.

EMERGENCY CONTACTS — CALL 911

<table>
<thead>
<tr>
<th>RESCUE SQUAD:</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOCTOR:</td>
</tr>
<tr>
<td>PHONE:</td>
</tr>
<tr>
<td>PARENT/GUARDIAN:</td>
</tr>
<tr>
<td>PHONE:</td>
</tr>
</tbody>
</table>

OTHER EMERGENCY CONTACTS

| NAME/RELATIONSHIP: |
| PHONE: |
| NAME/RELATIONSHIP: |
| PHONE: |

PARENT/GUARDIAN AUTHORIZATION SIGNATURE: ___________________________  DATE: __________

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 5/2014
State of New Jersey
DEPARTMENT OF EDUCATION

Sudden Cardiac Death Pamphlet

Sign-Off Sheet

Name of School District: ____________________________

Name of Local School: ____________________________

I/We acknowledge that we received and reviewed the Sudden Cardiac Death in Young Athletes pamphlet.

Student Signature: ____________________________

Parent or Guardian Signature: ____________________________

Date: ____________________________

New Jersey Department of Education 2014: pursuant to the Scholastic Student-Athlete Safety Act, P.L. 2013, c.71
Sports-Related Concussion and Head Injury Fact Sheet and
Parent/Guardian Acknowledgement Form

A concussion is a brain injury that can be caused by a blow to the head or body that disrupts normal functioning of the brain. Concussions are a type of Traumatic Brain Injury (TBI), which can range from mild to severe and can disrupt the way the brain normally functions. Concussions can cause significant and sustained neuropsychological impairment affecting problem solving, planning, memory, attention, concentration, and behavior.

The Centers for Disease Control and Prevention estimates that 300,000 concussions are sustained during sports related activities nationwide, and more than 62,000 concussions are sustained each year in high school contact sports. Second-impact syndrome occurs when a person sustains a second concussion while still experiencing symptoms of a previous concussion. It can lead to severe impairment and even death of the victim.

Legislation (P.L. 2010, Chapter 94) signed on December 7, 2010, mandated measures to be taken in order to ensure the safety of K-12 student-athletes involved in interscholastic sports in New Jersey. It is imperative that athletes, coaches, and parent/guardians are educated about the nature and treatment of sports related concussions and other head injuries. The legislation states that:

- All Coaches, Athletic Trainers, School Nurses, and School/Team Physicians shall complete an Interscholastic Head Injury Safety Training Program by the 2011-2012 school year.
- All school districts, charter, and non-public schools that participate in interscholastic sports will distribute annually this educational fact to all student athletes and obtain a signed acknowledgement from each parent/guardian and student-athlete.
- Each school district, charter, and non-public school shall develop a written policy describing the prevention and treatment of sports-related concussion and other head injuries sustained by interscholastic student-athletes.
- Any student-athlete who participates in an interscholastic sports program and is suspected of sustaining a concussion will be immediately removed from competition or practice. The student-athlete will not be allowed to return to competition or practice until he/she has written clearance from a physician trained in concussion treatment and has completed his/her district's graduated return-to-play protocol.

Quick Facts
- Most concussions do not involve loss of consciousness
- You can sustain a concussion even if you do not hit your head
- A blow elsewhere on the body can transmit an "impulsive" force to the brain and cause a concussion

Signs of Concussions (Observed by Coach, Athletic Trainer, Parent/Guardian)
- Appears dazed or stunned
- Forgets plays or demonstrates short term memory difficulties (e.g. unsure of game, opponent)
- Exhibits difficulties with balance, coordination, concentration, and attention
- Answers questions slowly or inaccurately
- Demonstrates behavior or personality changes
- Is unable to recall events prior to or after the hit or fall

Symptoms of Concussion (Reported by Student-Athlete)
- Headache
- Nausea/vomiting
- Balance problems or dizziness
- Double vision or changes in vision
- Sensitivity to light/sound
- Feeling of sluggishness or fogginess
- Difficulty with concentration, short term memory, and/or confusion
What Should a Student-Athlete do if they think they have a concussion?
- Don’t hide it. Tell your Athletic Trainer, Coach, School Nurse, or Parent/Guardian.
- Report it. Don’t return to competition or practice with symptoms of a concussion or head injury. The sooner you report it, the sooner you may return-to-play.
- Take time to recover. If you have a concussion your brain needs time to heal. While your brain is healing you are much more likely to sustain a second concussion. Repeat concussions can cause permanent brain injury.

What can happen if a student-athlete continues to play with a concussion or returns to play too soon?
- Continuing to play with the signs and symptoms of a concussion leaves the student-athlete vulnerable to second impact syndrome.
- Second impact syndrome is when a student-athlete sustains a second concussion while still having symptoms from a previous concussion or head injury.
- Second impact syndrome can lead to severe impairment and even death in extreme cases.

Should there be any temporary academic accommodations made for Student-Athletes who have suffered a concussion?
- To recover cognitive rest is just as important as physical rest. Reading, texting, testing—even watching movies can slow down a student-athletes recovery.
- Stay home from school with minimal mental and social stimulation until all symptoms have resolved.
- Students may need to take rest breaks, spend fewer hours at school, be given extra time to complete assignments, as well as being offered other instructional strategies and classroom accommodations.

**Student-Athletes who have sustained a concussion should complete a graduated return-to-play before they may resume competition or practice, according to the following protocol:**
- **Step 1:** Completion of a full day of normal cognitive activities (school day, studying for tests, watching practice, interacting with peers) without reemergence of any signs or symptoms. If no return of symptoms, next day advance.
- **Step 2:** Light Aerobic exercise, which includes walking, swimming, and stationary cycling, keeping the intensity below 70% maximum heart rate. No resistance training. The objective of this step is increased heart rate.
- **Step 3:** Sport-specific exercise including skating, and/or running: no head impact activities. The objective of this step is to add movement.
- **Step 4:** Non contact training drills (e.g. passing drills). Student-athlete may initiate resistance training.
- **Step 5:** Following medical clearance (consultation between school health care personnel and student-athlete’s physician), participation in normal training activities. The objective of this step is to restore confidence and assess functional skills by coaching and medical staff.
- **Step 6:** Return to play involving normal exertion or game activity.

For further information on Sports-Related Concussions and other Head Injuries, please visit:
- [www.cdc.gov/concussion/sports/index.html](http://www.cdc.gov/concussion/sports/index.html)
- [www.nfhs.com](http://www.nfhs.com)
- [www.ncaa.org/health-safety](http://www.ncaa.org/health-safety)
- [www.bianj.org](http://www.bianj.org)
- [www.atsnj.org](http://www.atsnj.org)

---

**Signature of Student-Athlete**

**Print Student-Athlete’s Name**

**Date**

**Signature of Parent/Guardian**

**Print Parent/Guardian’s Name**

**Date**
OVER THE COUNTER (OTC) 
MEDICATION AUTHORIZATION FORM

TO BE COMPLETED BY PARENT/GUARDIAN: 

Child’s Name ___________________________ Date of Birth ____________

Grade _________ Parent Signature __________________________

For the school year of August 20____ to June 20____

I give permission for the administration of the following over the counter 
medications (mark all that apply):

Bacitracin ointment ****** Cuts/ scrapes/sores  
Benadryl ***** Allergic Reactions  
Calamine lotion***** Rashes/itching bug bites  
Cortisone cream **** Itching/bug bites/ rashes  
Advil/Motrin/Ibuprofen ****Headache /Dental/ menstrual  
Tylenol/Acetaminophen **** Headache/ pain  
Allergic Eye Drops **** Irritated/ itching eyes  
Pepto Bismol ***** Stomach upset /Nausea  
Tums ********** Sour stomach/Acid indigestion  
Orajel****** Toothache  
Chloraseptic **********Sore Throat  
Cough drop ********** Cough  

Y N
Y N
Y N
Y N
Y N
Y N
Y N
Y N
ALLERGIES / HOME MEDICATIONS / IN SCHOOL MEDICATIONS

TO BE COMPLETED BY PARENT / GUARDIAN

Child's Name ____________________________ Grade _____

Date of Birth ________________

Please list allergies / reaction: _______________________

Please list medications that child takes at home:

________________________________________________

________________________________________________

Please list medications that your child will take at school. ***PLEASE GIVE SCHOOL NURSE PRESCRIPTION FROM DOCTOR WHICH STATES, "GIVE AT SCHOOL." PROVIDE MEDICATION FROM PHARMACY WITH PROPER LABEL. _______________________

________________________________________________

________________________________________________

Does your child have asthma? Yes _____ No _____
If yes, what medications are they taking? ________________
Provide asthma medication to school with a prescription.

If you have any questions or concerns please contact your school nurse.
AUTHORIZATION FOR EXCHANGE OF CONFIDENTIAL INFORMATION

Date __________

Student ___________________ Date of Birth __________

Grade __________

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

__________________________
Signature of Parent/Guardian

__________________________
School Nurse
REQUEST FOR EMERGENCY INFORMATION

To all Parents/Guardians: Occasionally children become ill while they are in school or they may have some accident (usually not serious). It is necessary for the school to have on file certain information which can be used should there be a need. Please supply the following information for emergency use. In the event that there is a change in this information, please notify the school promptly.

**Student's Name:**

**Address:**

**Parent/Guardian:**

**Home #/Cell #:** ________________ **Work #:** ________________

*If your child becomes ill or has an accident while in school and we are unable to reach you, please give the name of a relative or friend who can be notified.*

**Name:**

**Address:**

**Home #:** ________________ **Cell #:** ________________

**Relationship:**

*If you have a family doctor and wish us to call him if we cannot reach you, please supply their information.*

**Name:** ________________ **Phone #:** ________________

*Please provide the names and phone #’s of adults who have permission to pick up your child early from school. (Must be 18 years old)*

**Name:** ________________ **Phone #:** ________________

**Relationship:**

**Name:** ________________ **Phone #:** ________________

**Relationship:**

*marion p. thomas*  
*CHARTER SCHOOL*

*www.mptcs.org*

*“It takes a whole village to raise a child”*

**Primary School**
Prekindergarten - Kindergarten  
370 S. 7th St.  
Newark, NJ 07103  
PH: 973.621.0060, ext. 1  
FAX: 973.621.0061

**Elementary School**
1st – 3rd Grade  
370 S. 7th St.  
Newark, NJ 07103  
PH: 973.621.0060, ext. 2  
FAX: 973.621.2454

**The Academy**
4th & 5th Grade  
88-108 Shipman St.  
Newark, NJ 07102  
PH: 973.621.0060, ext. 3  
FAX: 973.643.4982

**Middle School**
6th - 8th Grade  
308 S. 9th St.  
Newark, NJ 07103  
PH: 973.621.0060, ext. 4  
FAX: 973.792.0066

**High School of Culinary & Performing Arts**
9th - 12th Grade  
125 Sussex Ave.  
Newark, NJ 07102  
PH: 973.621.0060, ext. 5

**Central Office**
P.O. Box 7117  
Newark, NJ 07107  
PH: 973.621.0060
# Seizure Action Plan

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

<table>
<thead>
<tr>
<th>Student's Name</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent/Guardian</td>
<td>Phone</td>
</tr>
<tr>
<td>Other Emergency Contact</td>
<td>Phone</td>
</tr>
<tr>
<td>Treating Physician</td>
<td>Phone</td>
</tr>
</tbody>
</table>

## Significant Medical History

### Seizure Information

<table>
<thead>
<tr>
<th>Seizure Type</th>
<th>Length</th>
<th>Frequency</th>
<th>Description</th>
</tr>
</thead>
</table>

Seizure triggers or warning signs: [ ]

Student's response after a seizure: [ ]

## Basic First Aid: Care & Comfort

Please describe basic first aid procedures:

- [ ] 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:

- [ ] Contact school nurse at [ ]
- [ ] Call 911 for transport to [ ]
- [ ] Notify parent or emergency contact
- [ ] Administer emergency medications as indicated below
- [ ] Notify doctor
- [ ] Other

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### 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

### 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)

<table>
<thead>
<tr>
<th>Emerg, Med.</th>
<th>Medication</th>
<th>Dosage &amp; Time of Day Given</th>
<th>Common Side Effects &amp; Special Instructions</th>
</tr>
</thead>
</table>

- [ ]

- [ ]

- [ ]

- [ ]

### 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:

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Physician Signature __________________ Date ____________

Parent/Guardian Signature __________________ Date ____________