



ELEMENTARY SCHOOL

Ronald Lieberman Principal
12 Hollywood Avenue, Fairfield, NJ 07004
(973) 439-1919
rlieberman@banyanschool.org

HIGH SCHOOL | LIFE ACADEMY

Janet Seabold Principal
471 Main Street, Little Falls, NJ 07424
(973) 785-1919
jseabold@banyanschool.org

Dear Parents/Guardians:

So that we may best meet the needs of your children, it is important that the enclosed health forms be completely filled out. Please sign, date and return the completed forms to the school nurse prior to the start of the new school year.

Enclosed are the following:

- Health & Emergency Card: **Please fill out both cards on both sides.** Sign and date them.
- Health History Form: Complete and sign.
- Physical Exam Form: Annual physicals are recommended. They are required by the State of NJ if participating on a team or intramural sport. New students are required by the State of NJ to provide a recent physical exam. The first two pages are to be completed by the parent/guardian. The second two pages are to be completed by the physician.
- Authorization to Administer Prescription Medication: Please have your child's physician complete this form if daily medication is required during school hours. All medications **must** be sent to school in the original pharmacy container which is labeled with the child's name, current date, medication and dosage.
- Emergency Medications: If your child has been diagnosed with a medical condition that requires emergency medications, the physician must complete the enclosed emergency action plans (Asthma, food allergy, seizure disorder). Please contact the nurse to discuss emergency action plans.
- Authorization To Administer Non-Prescription Medication: This form is for all students. Please **circle** the medications you are giving permission for the school nurse to administer to your child if needed during school hours. If your child will need over the counter medication not listed on this form, a doctor's order with signature & date is required.
- Annual Health Screenings: This form allows for your consent or refusal to scoliosis screening of your child.

Immunization records for new students must be submitted prior to the first day of the new school year. Your physician can fax this information to the school if you authorize them to do so. Please direct all health information to the attention of the school nurse. Fax: 973-439-1396

Reminder: Please call the school when your child will be absent.
We are a nut free school. Many of our student have allergies.

Please call us at 973-439-1919, ex.207 if you have any questions, or email us at BSNurse@banyanschool.org.

Sincerely,
Diane T. Boysen, RN
Lisa Sullivan, RN
Banyan Elementary School Nurses



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HEALTH HISTORY

(To be completed by Parent/Guardian)

Student Name - _____ Date of Birth _____
Home Address - _____ Sex - _____ M _____ F
City/State/Zip _____ Home Telephone # _____

Mother's/Guardian's Name _____ Work # _____
Occupation _____ Cell # _____
Father's/Guardian's Name _____ Work # _____
Occupation _____ Cell # _____

Does your child take any medication regularly? _____ yes _____ no

If yes, please list all of the medications your child is currently taking.

Has your child ever had, or presently have any of the following?

- | | |
|---|--------------------|
| 1. Allergies or sensitivities to any food or medication | _____ yes _____ no |
| 2. Asthma, seasonal allergies, wheezing | _____ yes _____ no |
| 3. Skin rashes or Eczema | _____ yes _____ no |
| 4. Seizures (if yes, please indicate date of last seizure _____) | _____ yes _____ no |
| 5. Heart Disease | _____ yes _____ no |
| 6. Diabetes | _____ yes _____ no |
| 7. Cancer | _____ yes _____ no |
| 8. Frequent colds, sore throats, ear infections | _____ yes _____ no |
| 9. Serious injury (if yes, please indicate type and date of injury) | _____ yes _____ no |
| 10. Surgery (if yes, please indicate type and date of surgery) | _____ yes _____ no |
| 11. Speech problems | _____ yes _____ no |
| 12. Congenital Anomalies | _____ yes _____ no |
| 13. Dental problems (date of last exam) | _____ yes _____ no |

Explanation of above -

Is there anything else that you would like me to know about your child? _____

Has your child had: Measles _____ Yes (date) _____ No
 Mumps _____ Yes (date) _____ No
 Chicken Pox _____ Yes (date) _____ No

Has your child been vaccinated for COVID-19: #1 _____ (date) #2 _____ (date)

Has your child been COVID Boosted: #1 _____ (date) #2 _____ (date)

Parent/Guardian's Signature _____ (date) _____

Thank you!

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 keep a 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.
☐ Medicines ☐ Pollens ☐ Food

☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	Yes	No
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
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?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
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 (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

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 _____

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9-2681/0410

■ **PREPARTICIPATION PHYSICAL EVALUATION** **THE ATHLETE WITH SPECIAL NEEDS:** **SUPPLEMENTAL HISTORY FORM**

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

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		
6. Do you regularly use a brace, assistive device, or prosthetic?	Yes	No
7. Do you use any special brace or assistive device 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.

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

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 _____

NOTE: The preparticipation 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

Name _____ Date of birth _____

PHYSICIAN REMINDERS

- 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 anxious?
 - 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 chewing 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?
- Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height _____	Weight _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
BP _____ / _____	Pulse _____	Vision R 20/____ L 20/____ Corrected <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance <ul style="list-style-type: none"> Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency) 		
Eyes/ears/nose/throat <ul style="list-style-type: none"> Pupils equal Hearing 		
Lymph nodes		
Heart* <ul style="list-style-type: none"> Murmurs (auscultation standing, supine, +/- Valsalva) Location of point of maximal impulse (PMI) 		
Pulses <ul style="list-style-type: none"> Simultaneous femoral and radial pulses 		
Lungs		
Abdomen		
Genitourinary (males only) ^b		
Skin <ul style="list-style-type: none"> HSV, lesions suggestive of MRSA, tinea corporis 		
Neurologic ^c		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional <ul style="list-style-type: none"> Duck-walk, single leg hop 		

*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

^bConsider GU exam if in private setting. Having third party present is recommended.

^cConsider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

- ☐ 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 _____

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, a 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) (print/type) _____ Date of exam _____

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 _____



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AUTHORIZATION FOR NON-PRESCRIPTION MEDICATION

School Year _____

Permission is given for the School Nurse to give the following non-prescription medications to my child during school hours. These medications are in stock in the Nurse's Office.

Please **CIRCLE** the medications and dosage amounts you are allowing to be administered.

1. Acetaminophen (Tylenol) – For headache , pain, or fever
Children's Chewable
Children's Liquid
Regular Strength Tablets
2. Ibuprofen (Motrin / Advil) – For headache, pain, or fever
Regular Strength Tablets - 1 or 2 tablets
3. Tums ^ For upset stomach or diarrhea - 1 or 2 tablets
4. Benadryl Liquid or Tablet - For systemic allergic reaction
(Dosage or amount depend on child's weight)

*** Any medications, other than those listed above, will need a physician's order, and must be provided by you in an original labeled container.

Student's Name: _____

Parent/Guardian Signature: _____

Date: _____



Wendy McNeill *Director* wmcneill@banyanschool.org

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AUTHORIZATION TO ADMINISTER PRESCRIPTION MEDICATION IN SCHOOL School Year _____

Student's Name _____

Address _____

City/State/Zip Code _____

Telephone _____

Parent/Guardian Name _____

Grade _____ Date of Birth _____

Name of Medication: _____

Dosage: _____

Time Administered & Directions: _____

Purpose/Diagnosis: _____

Physician Signature

Parent/Guardian Signature

Address

Date

Telephone Number



Wendy McNeill Director wmcneill@banyanschool.org

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Re: Annual Health Screenings

Dear Parents/Guardians:

Each year health screenings are conducted for our students. The health screenings include height, weight and blood pressure measurements as well as basic hearing and vision checks. A scoliosis screening is conducted biennially for students age 10 and older.

Scoliosis is an abnormal curvature of the spine that most commonly develops in the early adolescent years. The purpose of the scoliosis screening is to detect signs of curvature at its earliest stages.

The scoliosis screening takes approximately thirty seconds and is performed by viewing the spine while the student stands, as well as bends over. The screening requires visual inspection of the student's bare back; therefore, all students are screened individually and privacy is maintained.

Please note that school based health screenings do not replace the need for regular health care check-ups.

Please sign, date and return this form on or before the first day of school. Should you have any questions or concerns, please call and speak to the school nurse at (973) 439-1919 extension 207.

Sincerely,

Diane T. Boysen, RN

Lisa Sullivan, RN

Banyan School Nurse

Student's Name: _____

Parents/Guardian Name (printed): _____

Parents/Guardian Signature: _____

Date: _____

_____ No, I do not wish to have my child screened by the school nurse for scoliosis.

_____ Yes, I would like to have my child screened by the school nurse for scoliosis.

Food Allergy Action Plan

Name: _____ D.O.B.: ____/____/____

Allergy to: _____

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

Place
Student's
Picture
Here

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, 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 _____



Wendy McNeill Director wmcneill@banyanschool.org

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**Parental Request/Authorization for the Administration of Epinephrine
via Epi-Pen by the School Nurse or a Trained Delegate**

As the parent/guardian of _____, a student of
Banyan School, I authorize the School Nurse or a Substitute School Nurse, to administer
Epinephrine via Epi-Pen to my child for the treatment of Anaphylactic Reaction.

I acknowledge that in the absence of the School Nurse, New Jersey State Law allows the
emergency administration of one dose of Epinephrine, via Epi-Pen, by another school
employee designated and trained by the School Nurse.

I acknowledge that Banyan School and its agents shall incur no liability as a result of any
injury arising from the administration of the Epi-Pen to my child. I further agree to hold
harmless Banyan School and its agents against any claims arising out of the
administration of the Epi-Pen to my child.

I acknowledge that I am responsible for providing all medications ordered for the
treatment of allergic reaction in my child to the School Nurse, in original labeled
containers.

I acknowledge that this authorization is valid for the _____ School Year.

Parent Signature

Name of Parent (please print)

Date

Parent Phone #

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

- AMERICAN
LUNG
ASSOCIATION.**
IN NEW JERSEY

Asthma Treatment Plan – Student

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

(Please Print)

The Pediatric/Adult
Asthma Coalition
of New Jersey
Your Pathway to Asthma Control
NACAA approved this asthma action plan
www.pacnj.org

Sponsored by
AMERICAN
LUNG
ASSOCIATION
in partnership

NJ Health
Partnership for a Healthier NJ



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

HEALTHY (Green Zone) IIIIIII



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
<input type="checkbox"/> Advair® HFA <input type="checkbox"/> 45, <input type="checkbox"/> 115, <input type="checkbox"/> 230	2 puffs twice a day
<input type="checkbox"/> Aerospir™	<input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs twice a day
<input type="checkbox"/> Alvesco® <input type="checkbox"/> 80, <input type="checkbox"/> 160	<input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs twice a day
<input type="checkbox"/> Dulera® <input type="checkbox"/> 100, <input type="checkbox"/> 200	2 puffs twice a day
<input type="checkbox"/> Flovent® <input type="checkbox"/> 44, <input type="checkbox"/> 110, <input type="checkbox"/> 220	2 puffs twice a day
<input type="checkbox"/> Qvar® <input type="checkbox"/> 40, <input type="checkbox"/> 80	<input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs twice a day
<input type="checkbox"/> Symbicort® <input type="checkbox"/> 80, <input type="checkbox"/> 160	<input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs twice a day
<input type="checkbox"/> Advair Diskus® <input type="checkbox"/> 100, <input type="checkbox"/> 250, <input type="checkbox"/> 500	1 inhalation twice a day
<input type="checkbox"/> Asmanex® Twisthaler® <input type="checkbox"/> 110, <input type="checkbox"/> 220	<input type="checkbox"/> 1, <input type="checkbox"/> 2 inhalations <input type="checkbox"/> once or <input type="checkbox"/> twice a day
<input type="checkbox"/> Flovent® Diskus® <input type="checkbox"/> 50 <input type="checkbox"/> 100 <input type="checkbox"/> 250	1 inhalation twice a day
<input type="checkbox"/> Pulmicort Flexhaler® <input type="checkbox"/> 90, <input type="checkbox"/> 180	<input type="checkbox"/> 1, <input type="checkbox"/> 2 inhalations <input type="checkbox"/> once or <input type="checkbox"/> twice a day
<input type="checkbox"/> Pulmicort Respules® (Budesonide) <input type="checkbox"/> 0.25, <input type="checkbox"/> 0.5, <input type="checkbox"/> 1.0	1 unit nebulized <input type="checkbox"/> once or <input type="checkbox"/> twice a day
<input type="checkbox"/> Singulair® (Montelukast) <input type="checkbox"/> 4, <input type="checkbox"/> 5, <input type="checkbox"/> 10 mg	1 tablet daily
<input type="checkbox"/> Other	
<input type="checkbox"/> None	

Remember to rinse your mouth after taking inhaled medicine.

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

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:
 - ☐ _____
 - ☐ _____
 - ☐ _____

CAUTION (Yellow Zone) IIIII



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
<input type="checkbox"/> Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	2 puffs every 4 hours as needed
<input type="checkbox"/> Xopenex®	2 puffs every 4 hours as needed
<input type="checkbox"/> Albuterol <input type="checkbox"/> 1.25, <input type="checkbox"/> 2.5 mg	1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Duoneb®	1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Xopenex® (Levalbuterol) <input type="checkbox"/> 0.31, <input type="checkbox"/> 0.63, <input type="checkbox"/> 1.25 mg	1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Combivent RespiMat®	1 inhalation 4 times a day
<input type="checkbox"/> Increase the dose of, or add:	
<input type="checkbox"/> Other	

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

EMERGENCY (Red Zone) IIIII



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
<input type="checkbox"/> Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	4 puffs every 20 minutes
<input type="checkbox"/> Xopenex®	4 puffs every 20 minutes
<input type="checkbox"/> Albuterol <input type="checkbox"/> 1.25, <input type="checkbox"/> 2.5 mg	1 unit nebulized every 20 minutes
<input type="checkbox"/> Duoneb®	1 unit nebulized every 20 minutes
<input type="checkbox"/> Xopenex® (Levalbuterol) <input type="checkbox"/> 0.31, <input type="checkbox"/> 0.63, <input type="checkbox"/> 1.25 mg	1 unit nebulized every 20 minutes
<input type="checkbox"/> Combivent RespiMat®	1 inhalation 4 times a day
<input type="checkbox"/> Other	

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

Permission to Self-administer Medication:

- ☐ This student is capable and has been instructed in the proper method of self-administering of the non-nebulized inhaled medications named above in accordance with NJ Law.
- ☐ This student is not approved to self-medicate.

PHYSICIAN/APN/PA SIGNATURE _____

DATE _____

Physician's Orders

PARENT/GUARDIAN SIGNATURE _____

PHYSICIAN STAMP _____

REVISED AUGUST 2014

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

SEIZURE ACTION PLAN (SAP)



Name: _____ Birth Date: _____

Address: _____ Phone: _____

Emergency Contact/Relationship: _____ Phone: _____

Seizure Information

Seizure Type	How Long It Lasts	How Often	What Happens

How to respond to a seizure (check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> First aid – Stay. Safe. Side. | <input type="checkbox"/> Notify emergency contact at _____ |
| <input type="checkbox"/> Give rescue therapy according to SAP | <input type="checkbox"/> Call 911 for transport to _____ |
| <input type="checkbox"/> Notify emergency contact | <input type="checkbox"/> Other _____ |

First Aid for any seizure

- ☐ **STAY** calm, keep calm, begin timing seizure
- ☐ Keep me **SAFE** – remove harmful objects, don't restrain, protect head
- ☐ **SIDE** – turn on side if not awake, keep airway clear, don't put objects in mouth
- ☐ **STAY** until recovered from seizure
- ☐ Swipe magnet for VNS
- ☐ Write down what happens _____
- ☐ Other _____

When to call 911

- ☐ Seizure with loss of consciousness longer than 5 minutes, not responding to rescue med if available
- ☐ Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med if available
- ☐ Difficulty breathing after seizure
- ☐ Serious injury occurs or suspected, seizure in water

When to call your provider first

- ☐ Change in seizure type, number or pattern
- ☐ Person does not return to usual behavior (i.e., confused for a long period)
- ☐ First time seizure that stops on its' own
- ☐ Other medical problems or pregnancy need to be checked

When rescue therapy may be needed:

When and What to do

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

Care after seizure

What type of help is needed? (describe) _____

When is person able to resume usual activity? _____

Special instructions

First Responders: _____

Emergency Department: _____

Daily seizure medicine

Medicine Name	Total Daily Amount	Amount of Tab/Liquid	How Taken (time of each dose and how much)

Other information

Triggers: _____

Important Medical History: _____

Allergies: _____

Epilepsy Surgery (type, date, side effects) _____

Device: ☐ VNS ☐ RNS ☐ DBS Date Implanted _____

Diet Therapy: ☐ Ketogenic ☐ Low Glycemic ☐ Modified Atkins ☐ Other (describe) _____

Special Instructions: _____

Health care contacts

Epilepsy Provider: _____ Phone: _____

Primary Care: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

Pharmacy: _____ Phone: _____

My signature: _____ Date: _____

Provider Signature: _____ Date: _____