

GRADES PK-5 ANNUAL PHYSICAL EXAMINATION FORM

**PHYSICAL EXAMINATIONS MUST BE COMPLETED ONCE EVERY 365 DAYS
 AND RETURNED TO THE NURSES' OFFICE**
 e-mail: nurse@rutgersprep.org or fax: (732) 745-2685

Name: _____ Gender: M F Grade: _____ Date of Birth: ____ / ____ / ____

Medical Care Provider's Name: _____ Phone: _____ Fax: _____

Part I-Health History Questionnaire-To Be Completed By Parent Before Physical Evaluation

Does your child currently, or in the past, have any of the following conditions? Please complete the following checklist giving details and year when illness/injury occurred.

YES NO DATE

YES NO DATE

	YES	NO	DATE
Allergies: Medications, Food or Seasonal (list below)			
Allergy to Bee / Insect Sting (<i>Severe</i> reaction requiring Emergency Epinephrine)			
ADD / ADHD			
Anemia / Sickle Cell			
Arthritis			
Asthma / Reactive Airway Disease			
Back / Neck Injury			
Blood / Clotting Disorder			
Cancer / Leukemia			
Chickenpox-disease date			
Dental Problems			
Depression			
Diabetes			
Head Injury / Concussion			
Headaches / Migraines			

Hearing Deficit / Ear Tubes			
Heart Condition / Murmur / Rheumatic Fever / Blood Pressure			
Hepatitis			
Hernia			
Kidney / Bladder Disorder			
Lung Disease / TB / Pertussis			
Lyme Disease			
Mononucleosis			
Orthopedic Problems / Fractures			
Physical Disability/Activity Restrictions			
Seizure Disorder			
Surgery			
Speech Problems / Therapy			
Vision Impairment/Glasses/Contacts			
Other: (explain below)			

Explain other illness/health conditions and all "yes" answers listed above including relevant dates: _____

Is your child under any medical care/treatment now? ___YES ___NO Specify: _____

Is your child taking any medication on a regular basis (prescription or over-the-counter)? ___YES ___NO

List medication(s), dosage, frequency, and reasons for usage _____

****NJ State law requires written permission from a licensed medical provider and parent before ANY medication is administered in school. Please obtain a medication form(s) from the School Nurse's Office if your child requires medication while in school. All medication is overseen through the School Nurse's Office.**

I certify that the information provided herein is accurate to the best of my knowledge as of the date of my signature. I give consent for my child's health information to be shared on a "need-to-know" basis with faculty/staff and emergency care personnel who may be responsible for my child's care. I give consent for the School Nurse to exchange information with my child's health care provider regarding pertinent health issues. I agree to alert the School Nurse on any changes in medication and/or the health status of my child.

Printed Parent Name: _____

Parent Signature: _____ Signature Date: _____

THE COMPLETED AND SIGNED HEALTH HISTORY MUST BE REVIEWED BY THE EXAMINING PROVIDER AT THE TIME OF THE MEDICAL EXAMINATION

Part II-Physical Evaluation-Completed by the examining licensed provider MD, DO, APN or PA

Name _____ Grade _____ Gender M F Date of Birth _____

******FINDINGS OF PHYSICAL EVALUATION******

Height: _____ Weight: _____ Blood Pressure: ____/____ Pulse: _____ bpm. Vision: R 20/____ L 20/____ Contacts: Y/N Glasses: Y/N

INDICATORS	NORMAL?	ABNORMAL FINDINGS/COMMENTS
General Appearance	YES	
Head/Neck	YES	
Eyes/Sclera/Pupils	YES	
Ears	YES	
Gross Hearing	YES	
Nose/Mouth/Throat/Dental	YES	
Lymph Glands	YES	
Cardiovascular	YES	
Heart Rate	YES	
Rhythm	YES	
Murmur	ABSENT	
If murmur present		Standing makes it: Louder Softer No Change
		Squatting makes it: Louder Softer No Change
		Valsalva makes it: Louder Softer No Change
Femoral Pulses	YES	
Lungs: Auscultation/Percussion	YES	
Chest Contour	YES	
Skin	YES	
Abdomen (liver, spleen, masses)	YES	
Assessment of Physical Maturation or Tanner	YES	
Testicular Exam (Males Only)	YES	
Neck/Back/Spine:	YES	
Range of Motion	YES	
Scoliosis	ABSENT	
Upper Extremities: (ROM, Strength, Stability)	YES	
Lower Extremities: (ROM, Strength, Stability)	YES	
Neurological: Balance & Coordination	YES	
Hernia	ABSENT	
Evidence of Marfan Syndrome	ABSENT	

Most recent immunizations and dates administered (new students please attach full immunization record): _____

Medications currently prescribed, with dose and frequency:

Medication Name	Dosage	Frequency

Recent Injuries/Operations/Additional Observations: _____

General Diagnosis/Medical Concerns: _____

General Recommendations: _____

Conditions requiring clearance before physical education participation include, but are not limited to: Anaphylaxis; Atlantoaxial instability; Bleeding disorder; Hypertension; Congenital heart disease: Dysrhythmia; Mitral valve prolapse; Heart murmur; Cerebral palsy; Diabetes; Eating disorders; Heat illness history; One-kidney athletes; Hepatomegaly, Splenomegaly; Malignancy; Seizure disorder; Marfan syndrome; History of repeated concussion; Organ transplant recipient; Cystic fibrosis; Sickle cell disease; and/or One-eyed athletes or athletes with vision greater than 20/40 in one eye.

I have examined the above child and reviewed his/her health history prepared by the parent. It is my opinion that he/she is medically cleared to participate in all child care/school activities, including physical education and competitive contact sports without restriction unless noted above.

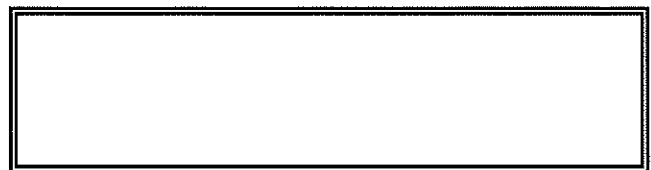
License Type: MD/DO APN PA

Licensed Medical Care Provider's Stamp:

Physician's/Provider's Name (Print) _____

Physician's/Provider's Signature _____

Today's Date: _____ Date of Examination: _____



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.

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

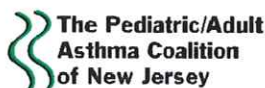
I do request that my child be ALLOWED to carry the following medication _____ for self-administration in school pursuant to N.J.A.C.:6A:16-2.3. I give permission for my child to self-administer medication, as prescribed in this Asthma Treatment Plan for the current school year as I consider him/her to 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



Your Pathway to Asthma Control!
Asthma Treatment Plan available at
www.pacnj.org

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FARE

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ Grade: _____ D.O.B.: _____

Diagnosis/Allergic to _____

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

PLACE
PICTURE
HERE

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

Extremely reactive to the following insects/foods: _____
THEREFORE:

- If checked, give epinephrine immediately for ANY symptoms if the allergen food was likely eaten / or stung
- If checked, give epinephrine immediately if the allergen was definitely eaten / or stung, 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.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell them the child is having anaphylaxis and may need epinephrine when they arrive.
- Consider giving additional medications following epinephrine:
 - Antihistamine
 - Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport them to ER even if symptoms resolve. Person should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS



NOSE

Itchy/runny nose, sneezing



MOUTH

Itchy mouth



SKIN

A few hives, mild itch



GUT

Mild nausea/ discomfort

FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA, GIVE EPINEPHRINE.

FOR MILD SYMPTOMS FROM A SINGLE SYSTEM AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine auto-injectable dose:

0.15 mg IM 0.3 mg IM

Diphenhydramine (i.e. Benadryl) by mouth

12.5 mg 25 mg 50mg other ___ mg

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

This student is **not** approved to self-medicate.

This student is capable and has been instructed in the proper method of self administering the initial dose of the auto-injectable epinephrine device named above in accordance with NJ State Law. The student shall carry the medication in the original labeled container noted above at all times in school and at school sponsored activities.

Medical Provider's stamp with address

Physician/DO/APN/PA Signature _____

Date _____

Trained delegates in the administration of initial dose of auto-injectable epinephrine

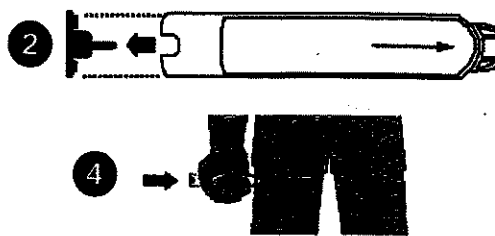
Name: _____ Location: _____

Name: _____ Location: _____

Name: _____ Location: _____

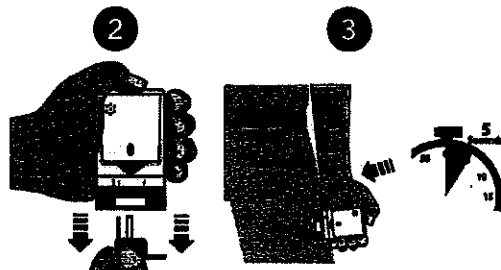
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

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.



Treat someone before calling Emergency Contacts. The first signs of a reaction can be mild, but symptoms can get worse quickly.

EMERGENCY CONTACTS— CALL 9-1-1

Medical Provider: _____ Phone: _____
 Parent/Guardian: _____ Phone: _____
 Parent/Guardian: _____ Phone: _____

OTHER EMERGENCY CONTACTS

Name/Relationship: _____ Phone: _____
 Name/Relationship: _____ Phone: _____

I give permission for my child to receive medication at school as prescribed in this Food Allergy & Anaphylaxis Emergency Care Plan. Medication shall be provided in its original prescription container and properly labeled by the pharmacist or medical provider. I 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. I understand this information will be shared with school staff on a need-to-know basis. This plan is in effect for the current school year and summer programs.

It is the parents' responsibility to inform the School Nurse when their child will be staying at an after-school sponsored activity. The School Nurse may train volunteers to act as a delegate to administer epinephrine via a pre-filled auto-injector to my child for anaphylaxis or possible anaphylaxis when the School Nurse is not physically present at the scene. I give consent for the trained delegate(s) to administer the initial dose of the epinephrine as indicated.

I acknowledge that Rutgers Preparatory School, Board of Trustees, employees and/or its agents shall incur no liability as a result of any injury arising from the administration (or self administration, if permitted) of medication to my child. I shall indemnify and hold harmless Rutgers Preparatory School, Board of Trustees, employees, and/or its agents against any claims arising out of the administration (or self administration, if permitted) of this medication to my child.

I request and give permission for my child to be ALLOWED to carry the above mentioned medication for self-administration as prescribed in this plan. I consider him/her responsible and capable of self-administering the medication(s) above.

I DO NOT give permission for my child to self administer his/her above mentioned medication(s).

Printed Parent Name: _____ Parent Signature: _____ Date: _____

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Rutgers Preparatory School

Medication Form

Office of School Nurse

Maureen Olsen, RN

Maria Bowers, RN

Phone: (732) 545-5600 ext. 224

Fax: (732) 745-2685

E-mail: nurse@rutgersprep.org

Dear Parent,

Only the School Nurse (or the student's parent) shall administer medication (prescription or over-the-counter) if a student is required to receive medication while attending school or school functions. All medications require written orders from a licensed medical provider and signature from the parent. All medication(s) shall be delivered to the School Nurse by the parent or other designated adult in the original labeled container with the student's name, medication name, medication route, dosage, time and/or other directions, date, and medical provider's name. For prescription medications, please ask the pharmacist to prepare two labeled containers. Herbs and dietary supplements are not considered medications and will not be administered. The parent is responsible to pick up any remaining medication at the end of treatment regime or at the end of the school year or it shall be destroyed seven days after the end of treatment. The only exception for which a student may be permitted to carry and self-administer his/her own medication shall be for a potentially life-threatening illness.

To Be Completed by Licensed Medical Provider:

Student: _____ D.O.B.: _____ Grade: _____

Diagnosis: _____

Name of Medication, Dosage, and Route: _____

Frequency and Indication To Be Administered: _____

Length of Time To Be Given: _____

Possible Side Effects: _____

Physician/DO/APN/PA Signature

Date

Medical Provider's Stamp with Address

I hereby request the School Nurse to administer the above medication to my child as prescribed by the medical provider. I give permission for the release and exchange of information between the school nurse and my child's health care providers 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. This authorization is effective for the current school year and summer programs.

I acknowledge that Rutgers Preparatory School, Board of Trustees, employees, and/or its agents shall incur no liability as a result of any injury arising from the administration of medication to my child. I shall indemnify and hold harmless Rutgers Preparatory School, Board of Trustees, employees, and/or its agents against any claims arising out of the administration of medication to my child.

Print Name of Parent

Signature of Parent

Date

8/21/2015