SCHOOL #

PATERSON PUBLIC SCHOOLS
PHYSICIAN'S ORDERS FOR ALLERGY EMERGENCY TREATMENT (20__-20__)

Date Given to Parent / Guardian ______________________ Date returned ______________________

Student's name ______________________ Birth date __________ Grade __________

The above student is allergic to: ______________________

Previous episode of anaphylaxis ☐ Yes ☐ No   Asthmatic ☐ Yes ☐ No

MEDICATIONS

ANTIHISTAMINE: ______________________
MEDICATION / DOSE / ROUTE

____
MEDICATION / DOSE / ROUTE

EPINEPHRINE: ☐ EpiPen (0.3mg) ☐ EpiPen Jr. (0.15 mg) ☐ Other __________
☐ Twinject (0.3mg) ☐ Twinject (0.15mg)
Repeat dose in __________ Minutes

		Give Checked Medication	
CONTACT	Contact only with allergen(s), __________ but with no symptoms	( )Epinephrine	( ) Antihistamine
SKIN	Hives, itchy rash, swelling of face or extremities	( )Epinephrine	( ) Antihistamine
MOUTH	Itching, tingling, burning, or swelling of lips tongue and mouth.	( )Epinephrine	( ) Antihistamine
THROAT	Tightening of throat, hoarseness, hacking cough	( )Epinephrine	( ) Antihistamine
GUT	Abdominal cramps, nausea, vomiting, diarrhea	( )Epinephrine	( ) Antihistamine
LUNGS	Repetitive cough, wheezing, shortness of breath	( )Epinephrine	( ) Antihistamine
HEART	Thready pulse, low blood pressure, fainting, pale or bluish skin	( )Epinephrine	( ) Antihistamine
GENERAL	Panic, sudden fatigue, chills, fear of impending doom	( )Epinephrine	( ) Antihistamine
OTHER		( )Epinephrine	( ) Antihistamine

****

MEDICATION ADMINISTRATION ORDER:
CHOOSE ONE

☐ Give Epinephrine only *(Delegate will be assigned)
☐ Give Antihistamine & Epinephrine at same time *(Delegate will be assigned)
☐ Give Antihistamine first, observe for further symptoms and give Epinephrine PRN

***Please note – in the absence of a school nurse, a trained delegate will give epinephrine and any antihistamine order will be disregarded**

****

☐ This student has been trained and is capable of self–administration of the following medication(s) named above:
☐ Epinephrine – single dose auto-injector
☐ Epinephrine & Antihistamine – single dose auto injector & premeasured dose of antihistamine
☐ This student is not capable of self-administration of the medications named above.
* Under NJ State Law, orders for antihistamine alone cannot be self administered.

Physician's signature ______________________ **Date** ______________________

Address ______________________ **Telephone** ______________________

Physician's Stamp:

School Doctor's signature ______________________ **Date** ______________________

Parents/Guardians,

The prescribed antihistamines and Epinephrine auto-injector(s) must be provided to the school nurse by the parent/guardian, and all medications must be provided in the original pharmacy container.
Permission for the self-administration of prescribed medication is effective for the school year for which it is granted and must be renewed for each subsequent school year.

Select one to sign and date.

1. I verify that my child ______________________________ has a potentially life threatening illness and **has been instructed in self-administration** of the prescribed medication in a life threatening situation. **I hereby give permission for my child to self-administer prescribed medication**. I further acknowledge that the Paterson Public School District shall incur no liability as a result of any injury arising from the self-administration of medication by my child. I shall indemnify and hold harmless the Paterson Public School District and its employees or agents against any claims arising out of self administration of medication by my child.

_______________________________ _______________

Parent/Guardian Signature Date

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2. I verify that my child ______________________________ has a potentially life threatening illness and is unable to self–administer the prescribed medication in a life threatening situation. I hereby request the school nurse to delegate (if applicable) to administer the prescribed medication to my child. I further acknowledge that the Paterson Public School District shall incur no liability as a result of any injury arising from administration of the medication to my child. I shall indemnify and hold harmless the Paterson Public School District and its employees or agents against any claims arising out of administration of medication to my child.

_______________________________ _______________

Parent/Guardian Signature Date

Please sign

I understand that under NJ State law, a trained delegate will be assigned to administer epinephrine to my child **in the absence of a school nurse**. Antihistamines may not be given by a delegate. In the absence of a school nurse, any antihistamine order will be disregarded and epinephrine will be administered by a trained delegate.

_______________________________ _______________

Parent / Guardian Signature Date

SCHOOL USE ONLY

_______________________________ _______________

Signature of School Nurse Date

SCHOOL YEAR ___________

SCHOOL # ________________

PATERSON PUBLIC SCHOOLS

AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS FOR ASTHMA OR OTHER POTENTIALLY LIFE THREATENING ILLNESS

STUDENT'S NAME ______________________________ DATE ________________ GRADE ____________

The above student is to take the following medication during school hours:

Medication: ______________________________ Dosage: ______________________________

Frequency: ______________________________ Route: ______________________________

Purpose: ______________________________ Diagnosis: ______________________________

1. It is my opinion that the medication can be self-administered during school hours by this student in school and on field trips. Instruction regarding proper care and administration procedure has been given to him/her and the parent /guardian. (A-2600) N.J.S.A. 18A:40-12.3

Family Physician's Name ______________________________ Telephone ______________________________

Physician's Signature ______________________________ Date ______________________________

****

2. I, ______________________________ the parent/guardian of ______________________________,
(print parent / guardian name) (print student's name)
give my permission for this medication to be self-administered during school hours. I am aware that the Paterson School District shall not incur any liability as a result of this self-administration, and I hold the district harmless in ANY injury or claims that arise as a result of my child's possession and/or self-administration of this medication.

Parent/Guardian's signature ______________________________ Telephone ______________________________

Address ______________________________ Date ______________________________

****

I HEREBY APPROVE THE ABOVE REQUEST FOR SELF-ADMINISTRATION OF THIS MEDICATION DURING SCHOOL HOURS.

______________________________ ______________________________
SCHOOL PHYSICIAN'S SIGNATURE DATE

All medication must be brought to the school nurse by a responsible adult, in the original container appropriately labeled by the pharmacy.

NOTE: THIS LETTER WILL BE KEPT ON FILE IN THE NURSE'S OFFICE FOR THE REMAINDER OF THIS SCHOOL YEAR. PERMISSION FOR THE SELF-ADMINISTRATION OF MEDICATION MUST BE RENEWED ANNUALLY.

School Nurse ______________________________ Date ______________________________

Revised 3/2010ec

SCHOOL # ________

SCHOOL YEAR ________

PATERSON PUBLIC SCHOOLS

AUTHORIZATION FOR THE ADMINISTRATION OF PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS TO BE GIVEN DURING REGULAR SCHOOL HOURS

Date Given ____________ Date Returned ____________ Medication Started (1st dose) ____________

Student's Name ________________________ DOB ____/____/____ Grade ________

PHYSICIAN: (medications to be given during regular school hours)

Please give the above named student the following;

Medication: ________________________

Dosage: ________________________

Time: ________________________

Purpose: ________________________

Diagnosis: ________________________

Medication to be taken during regular school hours:

Printed Name of Physician: ________________ Address: ____________

Physician's Signature: ________________ Telephone: ____________

Fax #: ____________

****

PARENT:

I hereby give my permission for the above prescription to be given to: ________________

(Print Student Name)

Parent/Guardian Signature ________________ **Date** ____________

APPROVED:

I hereby approve the above request for medication to be given during regular school hours.

School Doctor / Administrator ________________ Date ____________

****

All medications must be brought to the school by a responsible adult in the original container, appropriately labeled by the pharmacy. All medications must be counted by the school nurse, in the presence of the parent/guardian, and signed for.

All medications will be kept in a locked cabinet in the School Health Office, and administered by the School Nurse at the appropriate time.

School Nurse ________________ ☎ 973-321- ________

SCHOOL # ________ **SCHOOL YEAR** ________

PATERSON PUBLIC SCHOOLS

AUTHORIZATION FOR THE ADMINISTRATION OF PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS TO BE GIVEN DURING REGULAR SCHOOL HOURS

Date Given ____________ Date Returned ____________ Medication Started (1st dose) ____________

Student's Name ______________________ DOB ____/____/____ Grade ________

PHYSICIAN: (medications to be given during regular school hours)

Please give the above named student the following;

Medication: ______________________

Dosage: ______________________

Time: ______________________

Purpose: ______________________

Diagnosis: ______________________

Medication to be taken during regular school hours:

Printed Name of Physician: ______________________ Address: ____________

Physician's Signature: ______________________ Telephone: ____________

Fax #: ____________

****

PARENT:

I hereby give my permission for the above prescription to be given to: ______________________
(Print Student Name)

Parent/Guardian Signature ______________________ **Date** ____________

APPROVED:

I hereby approve the above request for medication to be given during regular school hours.

School Doctor / Administrator ______________________ Date ____________

****

All medications must be brought to the school by a responsible adult in the original container, appropriately labeled by the pharmacy. All medications must be counted by the school nurse, in the presence of the parent/guardian, and signed for.

All medications will be kept in a locked cabinet in the School Health Office, and administered by the School Nurse at the appropriate time.

School Nurse ______________________ ☎ 973-321-____________

SCHOOL YEAR ____________

SCHOOL # ____________

PATERSON PUBLIC SCHOOLS

AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS FOR ASTHMA OR OTHER POTENTIALLY LIFE THREATENING ILLNESS

STUDENT'S NAME ____________________ DATE ____________ GRADE ________

The above student is to take the following medication during school hours:

Medication: ____________________ Dosage: ____________________

Frequency: ____________________ Route: ____________________

Purpose: ____________________ Diagnosis: ____________________

1. It is my opinion that the medication can be self-administered during school hours by this student in school and on field trips. Instruction regarding proper care and administration procedure has been given to him/her and the parent /guardian. (A-2600) N.J.S.A. 18A:40-12.3

Family Physician's Name ____________________ Telephone ____________________

Physician's Signature ____________________ Date ____________________

****

2. I, ____________________ the parent/guardian of ____________________,
(print parent / guardian name) (print student's name)
give my permission for this medication to be self-administered during school hours. I am aware that the Paterson School District shall not incur any liability as a result of this self-administration, and I hold the district harmless in ANY injury or claims that arise as a result of my child's possession and/or self-administration of this medication.

Parent/Guardian's signature ____________________ Telephone ____________________

Address ____________________ Date ____________________

****

I HEREBY APPROVE THE ABOVE REQUEST FOR SELF-ADMINISTRATION OF THIS MEDICATION DURING SCHOOL HOURS.

____________________ ____________________
SCHOOL PHYSICIAN'S SIGNATURE DATE

All medication must be brought to the school nurse by a responsible adult, in the original container appropriately labeled by the pharmacy.

NOTE: THIS LETTER WILL BE KEPT ON FILE IN THE NURSE'S OFFICE FOR THE REMAINDER OF THIS SCHOOL YEAR. PERMISSION FOR THE SELF-ADMINISTRATION OF MEDICATION MUST BE RENEWED ANNUALLY.

School Nurse ____________________ Date ____________________

Revised 3/2010ec

PATERSON PUBLIC SCHOOL
ACTIVITY LIMITATION FORM

PS#: ___________ **(973) 321-** ___________ **DATE GIVEN:** _____________ **DATE RETURNED:** ________________

STUDENT: ____________________________________ **DOB:** _________________ **GRADE/HR:** _____________

Dear Doctor:
Our records indicate that the above named student requires an individual activity plan. Please provide a diagnosis and what accommodations, if any, are needed. Will you kindly check below the activities that the student may participate in?

PROGRAM OF FULL PARTICIPATION:

________ **YES** ________ **NO**

Relating *to* ***DIAGNOSIS***: ____

Student **MAY PARTICIPATE FULLY** in the school program **WITHOUT RESTRICTIONS**.

PHYSICIAN PRINT/ STAMP: ____ **PHONE:** ____________________________

PHYSICIAN SIGNATURE: ____

OR:

PROGRAM OF RESTRICTED ACTIVITY:

Start date: __________ **End Date:** __________

Relating to **DIAGNOSISI:** ______________________________________, *the following plan is indicated.*

Student **MAY PARTICIPATE** in the following activities:	YES	NO
WARM-UP EXERCISES: Stretching , walking		
LOW IMPACT AEROBICS: Jumping, hopping, jogging, dance, Tae Bo		
SWIMMING:		
STUNTS: Tumbling, rolling, balance, strength		
PHYSICAL FITNESS TESTING: Running, sit-ups, push-ups, pull-ups		
NON-CONTACT GAMES: Paddle ball, jump rope, badminton, tennis, bowling, other racket sports		
WEIGHT TRAINING PROGRAM: Free weights, treadmill		
TRACK AND FIELD: Sprints, intermediate & distance running, long jump, high jump, shot-put		
APPARATUS: Climbing, vaulting, support, suspension		
COMPETATTIVE GAMES: Soccer, hockey, basketball, baseball, softball, whiffleball, volleyball, speedball, touch football		
RECESS PLAY:		

STAIR CLIMBING (Circle) : **YES** **NO** * Number of flights of stairs allowed per day __________________

USE OF HELMET in gym: **YES** **NO** in recess: **YES** **NO** in class: **YES** **NO**

OTHER PROTECTIVE *and/*or **ASSISTIVE DEVICES** ***(please specify)***: ______________________________________

OTHER RESTRICTIONS: ____

PHYSICIAN PRINT /STAMP ___________________________________ **PHONE:** ____________________

PHYSICIAN SIGNATURE ____________________________________ **DATE:** ______________________

________ INITIAL EXAM ______ ANNUAL FOLLOW UP

Approved by School Physician: ____ **Date:** ________________

PATERSON PUBLIC SCHOOLS DISTRICT
90 DELAWARE AVENUE
PATERSON, NEW JERSEY 07503

NURSING SERVICES

Date ______________________________

Name and Address of Hospital or Health Care Provider:

____

____

____

To Whom It May Concern:

This is to certify that I, ____, the
(Parent/Guardian Name)
parent / legal guardian of _____________________________ Grade ____________, do
(Student Name)
hereby give my written consent for you to release or obtain any medical records that you might have in your possession concerning ______________________________ DOB ___________.
(Student Name)

Please send records to the attention of the School Nurse at:

School Name and Address → ____

____

____

Signature of
Parent or Guardian: ____

Signature of
School Nurse: ______________________________________ Telephone # 973-321- __ __ __

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2/2011
ec

PATERSON PUBLIC SCHOOLS DISTRICT
90 DELAWARE AVENUE
PATERSON, NEW JERSEY 07503

DEPARTMENT OF NURSING SERVICES

Date:______________________

Name and Address of School Nurse and Public School:

____

____

____

To Whom It May Concern:

This is to certify that I,____ the

Parent/Legal Guardian of ____ Grade____________, do

hereby give my written consent for you to release or obtain any medical records that you might have in your possession concerning____________________________________ DOB________________________

Please send records to the attention of the Hospital or Health Care Provider at:

Health Care Provider Address →____

____

____

Signature of
Parent or Guardian:____

Signature of
Health Care Provider:_______________________________________Telephone #:__________________

Signature of
School Nurse:____Telephone #:________________

PATERSON PUBLIC SCHOOLS DISTRICT
90 DELAWARE AVENUE
PATERSON, NEW JERSEY 07503

DEPARTMENT OF NURSING SERVICES

Parent/Guardian Permission to Release and Exchange Confidential Health Information

Student Name: ____________________________ **DOB:** ________________________

Address: __________________________________ **Student ID#** __________________

To Whom It May Concern:

This is to certify that I, ____________________________, the parent/legal guardian of ____________________, hereby authorize an exchange of information regarding my child, ____________________, to occur between the school and staff members who interact with______________________________.

This information may also be shared with the Intervention and Referral Service Team, Child Study Team, and /or the 504 Team if needed.

This authorization is in effect for the School Year: ________________________

Parent/Guardian Name (Print): ______________________________
Parent/Guardiain Signature: ________________________________ **Date:** ______________________
School Nurse: ____________________________________ Telephone Number: __________________

HEALTH OFFICE

School #24/Fine and Performing Arts Program

Grade______________________________ Home #__________________________

Student's Name____

Mother's Name____

Father's Name____

Address____

City____

Home Phone #____

Mother's Cell #____

Father's Cell #____

Parent Signature ____

EMERGENCY CONTACT NUMBERS TO FOLLOW:

1. Name____________________________

   Relation__________________________

   Emergency # ______________________

2. Name____________________________

   Relation__________________________

   Emergency # ______________________

3. Name____________________________

   Relation__________________________

   Emergency # ______________________

Individualized Healthcare Plan Severe Food Allergy

STUDENT NAME: ________________________ **DOB** __________

Student Address:
Home Phone:
Parent/Guardian:
Day/Work Phone:
Healthcare Provider:
Provider Phone:
IHP Written By:

School:
Teacher/Counselor:
Grade:
IHP Date:
IEP Date:
Review Date(s):
ICD-9 Codes:

Assessment Data	Nursing Diagnosis	Goals	Interventions	Outcome
Potential for anaphylactic shock secondary to severe food allergy. Asthma: YES/NO (circle one)	Risk for innefective breathing related to bronchospasm and inflammation of the airways secondary to allergic reaction.	Student will have FAAP/EAP and IHP in place to include student, parental and staff roles in preventing and mananging an anaphylactic reaction.	Secure medical documentation of food allergy, FAAP/EAP and information about food substitutions. • Educate school staff on early signs of potential anaphylaxis and appropriate steps to take in emergency care. - School wide training on recognition of signs of allergic reation. - Student specific training for classroom, administrative, cafeteria, custodial and transprotation personnel. - Train designated staff in the use of the epi auto-injector, first aid care, EMS contact. - Designated personnel receive copy of FAAP/EAP and IHP.	* Medical documentation receieved (FAAP/EAP) * Yearly staff awareness training conducted and documented. * Student specific training delivered and documented in student file. * Staff demonstrate proper use of epi auto-injector. In event of allergic reaction, staff responds according to FAAP/EAP. * Staff responds to student report of allergen exposure and supports student with self-care or by administering epi auto-injector. * Post crisis review conducted in the event of an allergen exposure.
		Student will demonstrate awareness of the significance of allergic reactions, symptoms and treatment.	Educate staff regarding allergen and institute environmental controls. • Have students/personnel wash hands or use hand wipes before and after food handling or consumption. Emphasize that hand sanitizer is NOT effective in removing food allergens from hands or surfaces. • Review food allergy and exposure prevention strategies with food service staff.	* Student will read food labels before ingestion. * Student will not accept food offered by others. * Student can demonstrate assertiveness when encountering situations that have potential to result in exposure to food allergen. * Student will identify allergic reactions, notify school personnel and treate immediately.

Individualized Healthcare Plan Severe Food Allergy

			• Secure medical documentation for food subsitutions. • Secure "emergency meal" from parent in event food allergen can not be avoided. • Review cleaning procedures with custodial staff. Establish a food safe environment for student with food allergies. • Notify classroom parents and staff of need to restrict presence of food allergen in student's classroom activiites. • Avoid use of food for instruction/reward purposes. • Adhere to bus policy about food consumption on the bus. • Minimum 2 week advance notice on field trips and other off campus activities. • Facilitate student particitpation in full range of school activities.	
		Establish a food safe environment for students with food allergies.	• Zero tolerance for bullying related to food allergy. • Educate student on assertiveness techniques. • Empower student to educate classmates.	* Student is NOT exposed to food allergen and has no allergic reactions.
	Potential for dimished self-esteem secondary to food allergy diagnosis.	Protect/Enhance student's self-image.	• Zero tolerance for bullying related to food allergy. • Educate student on assertiveness techniques. • Empower student to educate classmates.	* Student does not experience bullying or discrmination related to food allergy. * Student demonstrates positive self-esteem related to food allergy via verbal and non-verbal communication.

Parental/Guardian statement: ***I/We have read this plan and agree to its implementation.***
Signature:____ **Date:** __________