



HEALTH PACKET

Please complete and return the enclosed forms no later than August 23, 2024.
These forms must be received for the student to start school in September.

Forms should be returned to:

Union Catholic High School
Attn: Health Records
1600 Martine Avenue
Scotch Plains, NJ 07076

Union Catholic High School
Health Office

Health Forms Checklist

****All forms that require signatures must be dated on or after July 1, 2024. ****
Medication, inhalers and EpiPens can be brought to Ms. Nuwer, Director of Student Support Services, in September.

All Freshmen and Transfer Students:

- _____ Scoliosis Screening Form (Grades 9 and 11)
- _____ Preparticipation Physical Evaluation: Physical Examination Form (signed and dated by physician)
- _____ Immunization Record (Due at the time of Registration, if you have not already done so, email a copy to Meg Nuwer at mnuwer@unioncatholic.org)

Student Athletes: (all Health Forms must be returned to the Health Office)

- _____ Preparticipation Physical Evaluation: Clearance (signed and dated by physician)
- _____ Preparticipation Physical Evaluation: History Form
- _____ Preparticipation Physical Evaluation: Special Needs Supplemental Form (if applicable)
- _____ Health History Update (completed and signed by parent)
- _____ Additional forms for athletes can be found under Athletic Forms on the UC athletics site: <https://ucvikings.com>

Students who require medication administration during school day:

All medications must be submitted to Meg Nuwer. No student may bring medications to school without the following:

- _____ Medication Permission Form (dated after July 1, 2023 and signed by physician and parent)
- _____ Medication in original container (with pharmacy label including student's name)

Students who have inhalers prescribed by physician:

- _____ Asthma Treatment Plan – 2 sided form (dated and signed by physician and parent)
- _____ Inhaler in original box (with pharmacy label) If the student will carry his/her inhaler then he/she must have written permission on the Asthma Treatment Plan Form from you and the doctor to carry the inhaler.

Students who have an EpiPen:

- _____ Food Allergy Plan – 2 sided form (dated and signed by physician and parent)
- _____ EpiPen in original box (with pharmacy label) If the student will carry his/her EpiPen then he/she must have written permission on the Food Allergy Plan Form from you and the doctor to carry the EpiPen.

Union Catholic High School
Health Office
Phone: (908) 889-1600, Ext. 311 – Email: ucnurse@unioncatholic.org
Fax: (908) 889-1615

Notice of Scoliosis Screening

March, 2024

Dear Parent/ Guardian:

New Jersey state law requires that we conduct a scoliosis screening program for students in grades 9 and 11.

Scoliosis is a spinal deformity in which the spine curves to the left or right. Most scoliosis curves appear just before adolescence, at a time of rapid growth of the skeleton. Many curves require no treatment but those that do may worsen if left untreated. The purpose of the screening program is to recognize scoliosis at its earliest stage.

The screening is painless, involving only inspection of the spine by a trained examiner.

You have the right to have your student excluded from the screening. Scoliosis screening is part of all school and sports physical examinations.

Please complete the form and return it to the Health Office after July 1, 2024.

Name of Student _____

_____ I request that my student be exempt from screening.

_____ I request that my student be screened.

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 _____	☐ Male ☐ Female
BP _____ / _____ (_____ / _____)	Pulse _____	Vision R 20/ _____ L 20/ _____ Corrected ☐ Y ☐ 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 equalHearing		
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 _____

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 _____ 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: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ 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: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ 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 _____

■ 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		
	Yes	No
6. Do you regularly use a brace, assistive device, or prosthetic?		
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 _____

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

New Jersey Department of Education
Health History Update Questionnaire

Name of School: _____

To participate on a school-sponsored interscholastic or intramural athletic team or squad, each student whose physical examination was completed more than 90 days prior to the first day of official practice shall provide a health history update questionnaire completed and signed by the student's parent or guardian.

Student: _____ Age: _____ Grade: _____

Date of Last Physical Examination: _____ Sport: _____

Since the last pre-participation physical examination, has your son/daughter:

1. Been medically advised not to participate in a sport? Yes ☐ No ☐

If yes, describe in detail:

2. Sustained a concussion, been unconscious or lost memory from a blow to the head? Yes ☐ No ☐

If yes, explain in detail:

3. Broken a bone or sprained/strained/dislocated any muscle or joints? Yes ☐ No ☐

If yes, describe in detail:

4. Fainted or "blacked out?" Yes ☐ No ☐

If yes, was this during or immediately after exercise?

5. Experienced chest pains, shortness of breath or "racing heart?" Yes ☐ No ☐

If yes, explain

6. Has there been a recent history of fatigue and unusual tiredness? Yes ☐ No ☐

7. Been hospitalized or had to go to the emergency room? Yes ☐ No ☐

If yes, explain in detail

8. Since the last physical examination, has there been a sudden death in the family or has any member of the family under age 50 had a heart attack or "heart trouble?" Yes ☐ No ☐

9. Started or stopped taking any over-the-counter or prescribed medications? Yes ☐ No ☐

10. Been diagnosed with Coronavirus (COVID-19)? Yes ☐ No ☐

If diagnosed with Coronavirus (COVID-19), was your son/daughter symptomatic? Yes ☐ No ☐

If diagnosed with Coronavirus (COVID-19), was your son/daughter hospitalized? Yes ☐ No ☐

Date: _____ Signature of parent/guardian: _____

Please Return Completed Form to the School Nurse's Office

**Union Catholic High School
Health Office**

2024-2025 School Year

Authorization for Medication(s) taken during school hours.

All students who need prescription or nonprescription medication during school hours must complete this form.

- The form must be completed and signed by physician.
- The form must be signed by parent.
- Medication must be brought to Ms. Nuwer, Director of Student Support Services, in the original prescription or over-the-counter bottle.

Student Name: _____

Grade: _____

TO BE COMPLETED BY PHYSICIAN

Name of Medication 1: _____ Dose: _____

Time*: _____ * May delay dose on field trip days until student returns to school. Please circle Yes or No

Reason for medication: _____

Significant side effects: _____

Name of Medication 2: _____ Dose: _____

Time*: _____ * May delay dose on field trip days until student returns to school. Please circle Yes or No

Reason for medication: _____

Significant side effects: _____

Name of Medication 3: _____ Dose: _____

Time*: _____ * May delay dose on field trip days until student returns to school. Please circle Yes or No

Reason for medication: _____

Significant side effects: _____

Physician's Name: _____ Physician's Signature: _____ Date: _____

Physician's Address: _____ Physician's Phone: _____

Not valid without official stamp.

TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for my student to receive the above medication(s) during school hours.

Parent/Guardian name: _____

Parent/Guardian signature: _____ Date: _____

PLACE
PICTURE
HERE

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 allergens: _____

THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was **LIKELY** eaten, for **ANY** symptoms.

☐ If checked, give epinephrine immediately if the allergen was **DEFINITELY** eaten, even if no symptoms are apparent.

FOR ANY OF THE FOLLOWING:
SEVERE SYMPTOMS



LUNG

Shortness of breath, wheezing, repetitive cough



HEART

Pale or bluish skin, faintness, weak pulse, dizziness



THROAT

Tight or hoarse throat, trouble breathing or swallowing



MOUTH

Significant swelling of the tongue 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 emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders 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 patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS



NOSE

Itchy or runny nose, sneezing



MOUTH

Itchy mouth



SKIN

A few hives, mild itch



GUT

Mild nausea or 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 Brand or Generic: _____

Epinephrine Dose: ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

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

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE

DATE

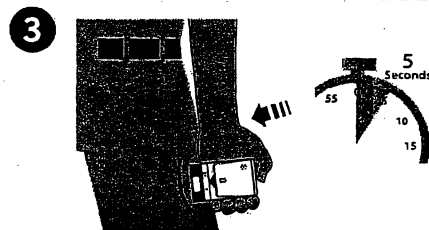
PHYSICIAN/HCP AUTHORIZATION SIGNATURE

DATE



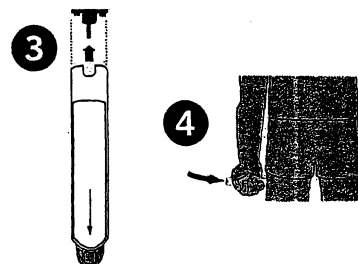
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

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



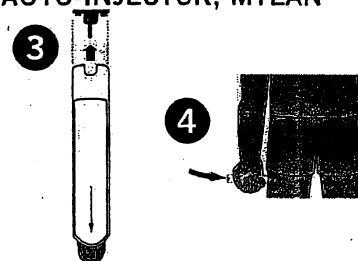
HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR, MYLAN

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



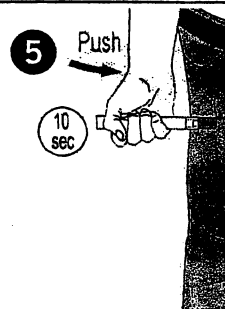
HOW TO USE EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN

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



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

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



ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

Asthma Treatment Plan – Student

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

The Pediatric/Adult
Asthma Coalition
of New Jersey
"Your Pathway to Asthma Control"
PACNJ approved Plan available at
www.pacnj.org

Sponsored by
AMERICAN
LUNG
ASSOCIATION
IN NEW JERSEY

NJ Health
New Jersey Department of Health



(Please Print)

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

HEALTHY (Green Zone)



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
☐ Advair® HFA ☐ 45, ☐ 115, ☐ 230	2 puffs twice a day
☐ Aerospir™	☐ 1, ☐ 2 puffs twice a day
☐ Alvesco® ☐ 80, ☐ 160	☐ 1, ☐ 2 puffs twice a day
☐ Dulera® ☐ 100, ☐ 200	2 puffs twice a day
☐ Flovent® ☐ 44, ☐ 110, ☐ 220	2 puffs twice a day
☐ Qvar® ☐ 40, ☐ 80	☐ 1, ☐ 2 puffs twice a day
☐ Symbicort® ☐ 80, ☐ 160	☐ 1, ☐ 2 puffs twice a day
☐ Advair Diskus® ☐ 100, ☐ 250, ☐ 500	1 inhalation twice a day
☐ Asmanex® Twisthaler® ☐ 110, ☐ 220	☐ 1, ☐ 2 inhalations ☐ once or ☐ twice a day
☐ Flovent® Diskus® ☐ 50 ☐ 100 ☐ 250	1 inhalation twice a day
☐ Pulmicort Flexhaler® ☐ 90, ☐ 180	☐ 1, ☐ 2 inhalations ☐ once or ☐ twice a day
☐ Pulmicort Respules® (Budesonide) ☐ 0.25, ☐ 0.5, ☐ 1.0	1 unit nebulized ☐ once or ☐ twice a day
☐ Singulair® (Montelukast) ☐ 4, ☐ 5, ☐ 10 mg	1 tablet daily
☐ Other	
☐ 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)



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
☐ Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	2 puffs every 4 hours as needed
☐ Xopenex®	2 puffs every 4 hours as needed
☐ Albuterol ☐ 1.25, ☐ 2.5 mg	1 unit nebulized every 4 hours as needed
☐ Duoneb®	1 unit nebulized every 4 hours as needed
☐ Xopenex® (Levalbuterol) ☐ 0.31, ☐ 0.63, ☐ 1.25 mg	1 unit nebulized every 4 hours as needed
☐ Combivent Respimat®	1 inhalation 4 times a day
☐ Increase the dose of, or add:	
☐ Other	

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

EMERGENCY (Red Zone)



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
☐ Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	4 puffs every 20 minutes
☐ Xopenex®	4 puffs every 20 minutes
☐ Albuterol ☐ 1.25, ☐ 2.5 mg	1 unit nebulized every 20 minutes
☐ Duoneb®	1 unit nebulized every 20 minutes
☐ Xopenex® (Levalbuterol) ☐ 0.31, ☐ 0.63, ☐ 1.25 mg	1 unit nebulized every 20 minutes
☐ Combivent Respimat®	1 inhalation 4 times a day
☐ 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 _____

Physician's Orders

DATE _____

PARENT/GUARDIAN SIGNATURE _____

PHYSICIAN STAMP _____

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

REVISED AUGUST 2014

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PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM AS WELL. ➡

Asthma Treatment Plan – Student Parent Instructions

The **PACNJ Asthma Treatment Plan** is designed to help everyone understand the steps necessary for the individual student to achieve the goal of controlled asthma.



1. **Parents/Guardians:** Before taking this form to your Health Care Provider, complete the top left section with:
 - Child's name
 - Child's doctor's name & phone number
 - Parent/Guardian's name & phone number
 - Child's date of birth
 - An Emergency Contact person'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.

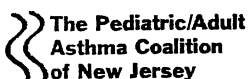
RECOMMENDATIONS ARE EFFECTIVE FOR ONE (1) SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY

- ☐ 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



"Your Pathway to Asthma Control"
PACNJ approved Plan available at
www.pacnj.org

Disclaimer: The use of this Pediatric/Adult Asthma Treatment Plan and its content is at your own risk. The content is provided on an "as is" basis. The American Lung Association of the Mid-Atlantic (ALAM-A), the Pediatric/Adult Asthma Coalition of New Jersey and all affiliates disclaim all warranties, express or implied, statutory or otherwise, including but not limited to the implied warranties of merchantability, non-infringement of third parties' rights, and fitness for a particular purpose. ALAM-A makes no representations or warranties about the accuracy, reliability, completeness, currency, or timeliness of the content. ALAM-A makes no warranty, representation or guaranty that the information will be uninterrupted or error free or that any defects can be corrected. In no event shall ALAM-A be liable for any damages (including, without limitation, incidental and consequential damages, personal injury, wrongful death, lost profits, or damages resulting from data or business interruption) resulting from the use or inability to use the content of this Asthma Treatment Plan whether based on warranty, contract, tort or any other legal theory, and whether or not ALAM-A is advised of the possibility of such damages. ALAM-A and its affiliates are not liable for any claim, whatsoever, caused by your use or misuse of the Asthma Treatment Plan, nor of this website.

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