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 |

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**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**

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☐ 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:**

**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

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

# Paterson Public Schools
# Department of Early Childhood Education
# Preschool Activity Limitation Form

STUDENT_____ DOB:_____ GRADE_____

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?

**PROGRAM OF FULL PARTICIPATION with NO RESTRICTIONS:** _____YES _____NO

Relating to DIAGNOSIS: _____

**PHYSICIAN PRINT/STAMP**_____ phone:_____

**PHYSICIAN SIGNATURE**:_____DATE:_____

Or:

**PROGRAM OF RESTRICTED ACTIVITY:** **Start Date**_____ **End Date**_____

**Relating to DIAGNOSIS:** **,the following plan is indicated.**

| Student MAY PARTICIPATE in the following activities: | Yes | No |
|---|---|---|
| WARM UP EXCERCISES: Stretching, walking | | |
| LOW IMPACT AEROBIC: jumping, hopping, dance | | |
| Stunts: tumbling, rolling on mats | | |
| Non-Contact games: jump rope, ball (no hard balls used) | | |
| Gym: free play, use ball (no hard balls used) | | |
| Apparatus: low balance beam, tricycle, scooter | | |
| Climbing: Max height on slide 48 inches, rock crawl (40") little tikes apparatus | | |
| Outdoor play: swing, slide, running , free play | | |

Stair climbing (circle) YES NO * number of flights of stairs per day_____

USE OF HELMET : GYM ___Yes ____No RECESS: ____Yes ___NO IN CLASS___Yes__No

Other protective/assistive devices (please specify):_____

Other restrictions:_____

PHYSICIAN PRINT/STAMP:_____PHONE:_____

PHYSICIAN SIGNATURE:_____ DATE:_____

Approved by School Physician_____ Date_____