Preparticipation Physical Evaluation Medical Eligibility Form

The Medical Eligibility Form is the only form that should be submitted to school. It should be kept on file with the student's school health record.

Student Athlete's Name _____ Date of Birth _____

Date of Exam _____

- o Medically eligible for all sports without restriction
- o Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of
- o Medically eligible for certain sports
- o Not medically eligible pending further evaluation
- o Not medically eligible for any sports

Recommendations: _____

I have reviewed the history form and examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings- are 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 medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Signature of physician, APN, PA _____ Office stamp (optional)

Address: _____

Name of healthcare professional (print) _____

I certify I have completed the Cardiac Assessment Professional Development Module developed by the New Jersey Department of Education.

Signature of healthcare provider _____

Shared Health Information

Allergies _____

Medications:

Other information: _____

Emergency Contacts: _____

**This form has been modified to meet the statutes set forth by New Jersey.*

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

Allergy and Anaphylaxis Emergency Plan

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Child's name: _____ **Date of plan:** _____

Date of birth: ____/____/_____ **Age** _____ **Weight:** _____kg

Child has allergy to _____

Attach child's photo

Child has asthma. ☐ Yes ☐ No (If yes, higher chance severe reaction)
Child has had anaphylaxis. ☐ Yes ☐ No
Child may carry medicine. ☐ Yes ☐ No
Child may give him/herself medicine. ☐ Yes ☐ No (If child refuses/is unable to self-treat, an adult must give medicine)

IMPORTANT REMINDER
Anaphylaxis is a potentially life-threating, severe allergic reaction. If in doubt, give epinephrine.

For Severe Allergy and Anaphylaxis
What to look for

If child has ANY of these severe symptoms after eating the food or having a sting, **give epinephrine**.

- Shortness of breath, wheezing, or coughing
- Skin color is pale or has a bluish color
- Weak pulse
- Fainting or dizziness
- Tight or hoarse throat
- Trouble breathing or swallowing
- Swelling of lips or tongue that bother breathing
- Vomiting or diarrhea (if severe or combined with other symptoms)
- Many hives or redness over body
- Feeling of "doom," confusion, altered consciousness, or agitation

☐ **SPECIAL SITUATION**: If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s): _____. Even if child has MILD symptoms after a sting or eating these foods, **give epinephrine**.

Give epinephrine!
What to do

1. Inject epinephrine right away! Note time when epinephrine was given.
2. Call 911.
   - Ask for ambulance with epinephrine.
   - Tell rescue squad when epinephrine was given.
3. Stay with child and:
   - Call parents and child's doctor.
   - Give a second dose of epinephrine, if symptoms get worse, continue, or do not get better in 5 minutes.
   - Keep child lying on back. If the child vomits or has trouble breathing, keep child lying on his or her side.
4. Give other medicine, if prescribed. Do not use other medicine in place of epinephrine.
   - Antihistamine
   - Inhaler/bronchodilator

For Mild Allergic Reaction
What to look for

If child has had any mild symptoms, **monitor child.**
Symptoms may include:

- Itchy nose, sneezing, itchy mouth
- A few hives
- Mild stomach nausea or discomfort

Monitor child
What to do

Stay with child and:

- Watch child closely.
- Give antihistamine (if prescribed).
- Call parents and child's doctor.
- If more than 1 symptom or symptoms of severe allergy/anaphylaxis develop, use epinephrine. (See "For Severe Allergy and Anaphylaxis.")

Medicines/Doses

Epinephrine, intramuscular (list type): _____ Dose: ☐ 0.10 mg (7.5 kg to less than13 kg)*
☐ 0.15 mg (13 kg to less than 25 kg)
☐ 0.30 mg (25 kg or more)

Antihistamine, by mouth (type and dose): _____ (*Use 0.15 mg, if 0.10 mg is not available)

Other (for example, inhaler/bronchodilator if child has asthma): _____

_____ _____ _____ _____
Parent/Guardian Authorization Signature **Date** **Physician/HCP Authorization Signature** **Date**

Allergy and Anaphylaxis Emergency Plan

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Child's name: _____ **Date of plan:** _____

Additional Instructions:

Contacts

Call 911 / Rescue squad: _____

Doctor: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Other Emergency Contacts

Name/Relationship: _____ Phone: _____

Name/Relationship: _____ Phone: _____

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 date of birth
   - Child's doctor's name & phone number
   - An Emergency Contact person's name & phone number
   - Parent/Guardian'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 _____

The Pediatric/Adult Asthma Coalition of New Jersey

"Your Pathway to Asthma Control"

PACNJ approved Plan available at www.pacnj.org

The Pediatric/Adult Asthma Coalition of New Jersey, sponsored by the American Lung Association in New Jersey. This publication was supported by a grant from the New Jersey Department of Health and Senior Services, with funds provided by the U.S. Centers for Disease Control and Prevention under Cooperative Agreement 5U59EH000491-04. Its content are solely the responsibility of the authors and do not necessarily represent the official views of the New Jersey Department of Health and Senior Services or the U.S. Centers for Disease Control and Prevention. Although this document has been funded wholly or in part by the United States Environmental Protection Agency under Agreement XA96296601-0 to the American Lung Association in New Jersey, it has not gone through the Agency's publications review process and therefore, may not necessarily reflect the views of the Agency and no official endorsement should be inferred. Information in this publication is not intended to diagnose health problems or take the place of medical advice. For asthma or any medical condition, seek medical advice from your child's or your health care professional.

Sponsored by

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)

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
☐ 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 this medicine_____ ____minutes before exercise.

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
☐ Combivent® ☐ Maxair® ☐ Xopenex®	2 puffs every 4 hours as needed
☐ Ventolin® ☐ Pro-Air® ☐ Proventil®	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
☐ 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
☐ Combivent® ☐ Maxair® ☐ Xopenex®	2 puffs every 20 minutes
☐ Ventolin® ☐ Pro-Air® ☐ Proventil®	2 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
☐ Other	

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:
  - ○ _____
  - ○ _____
  - ○ _____

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

REVISED AUGUST 2013
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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_____

PARENT/GUARDIAN SIGNATURE_____

PHYSICIAN STAMP

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

From the Desk of The School Nurse

Parents,

Please complete the form below. This form should be given to your students' current middle school nurse in order to request official health records to be sent to Red Bank Catholic High School.

I give permission to have the original health records of

_____

Student Name

Released to Red Bank Catholic High School, 112 Broad Street Red Bank, NJ 07701

Signature of parent/ guardian: _____

Current Middle School**:** _____

Very Important: Records should be received by Red Bank Catholic HS by June 30.

Thank you,

JoAnn Winters, RN
Red Bank Catholic High School
jwinters@redbankcatholic.com
732.747.1774 ext. 119

Red Bank Catholic High School
Annual Health and Emergency Form

Dear Parent or Legal Guardian:

This form is sent to you for the purpose of obtaining updated information concerning the health history of your child. Please notify me of any changes in health or medication they are receiving so I can better address their needs. It is also frequently necessary to contact a parent during the school day because of sudden illness or injury.

PLEASE COMPLETE THE FORM ENTIRELY AND RETURN TO RED BANK CATHOLIC HS

Student's Legal Name:_____Birthday_____

Address: _____City_____

State_____Zip _____Phone_____

List and illnesses, operations or injuries and explain: Please provide doctor's restrictions and accommodations needed during the school day._____

_____

_____

List any medications that your child takes on a regular basis or as needed: Please provide doctor's order and medications that will be needed during school hours.

Mother's Name _____ Father's Name _____

Business Phone _____ Business Phone _____
Cell Phone_____ Cell Phone_____
Home Phone_____ Home Phone_____

Please list the names and phone number of two adults whom you authorize the nurse to call in case of emergency. Your child will be released to one of the following if we are unable to reach you.

Name_____ Phone_____Cell_____

Name_____Phone_____Cell_____

Parent/ Guardian signature_____ Date _____

Sincerely,

JoAnn Winters, RN

Red Bank Catholic High School

From the Desk of the School Nurse

JoAnn Winters, RN

Medication Policy

Medication, in general, should be given in the home, but in event of specific problems, it can be given at school. According to New Jersey State Guidelines for the administration of medication in school, the following requirements
must be met:

1. A doctor's written prescription with:
    a. The child's name
    b. The dosage and frequency of administration including the duration the medication should be given, or if it to be given as needed.
    c. Reason for medication.

2.There are two forms for medication, self- medication order. The forms need to be signed by your child's doctor. **Self- medication is only for inhalers, epi-pens and diabetic supplies.**

3. Medication must be in its original container. Over the counter medication must be a new bottle with an unbroken seal.

4. Parent's note of permission.

It is the parent's responsibility to provide the nurse with any needed medication. All medication will be locked in the medication cabinet, and arrangements will be made for all remaining medication to be picked up at the end of the school year.

However, the school reserves the right to reject extraordinary and unusual requests for the administration of medication.

Medication Order

_____is being treated for_____
and is permitted to take the following medication at school.

Name of Medicaton_____

Frequency :Time_____ Daily_____

Dosage_____ tablet(s) Capsule(s) or _____ puffs of inhaler or
Other_____

Duration or order_____: or short term_____

Any adverse reaction to be expected_____

Physician Signature_____Date_____

Physicians Stamp and number

Authorization for the school nurse to administer the above medication is hereby given.

_____ _____
Signature of parent/guardian Date

RED BANK CATHOLIC HIGH SCHOOL
112 BROAD STREET RED BANK , NJ 07701 732 747 1774 FAX 732 747 1936

Self-Medication Order

The administration of medication to a student during school hours will be permitted only when student's physician certifies in writing that the administration of medication during school hours is essential to the health of the student. The parent/guardian must provide a written request for the administration of the prescribed medication at school.

Part 1- to be completed by student's physician:

I certify that it is essential to the health of _____
that the following medication be administered during school hours as directed.

Diagnosis: _____
Name of Medication_____
Dosage/Mode/Frequency_____
Side effects, if any_____
Student may carry medication: Yes_____ No_____
Permission is granted for self - medication. Student has been trained and is proficient in self- administration of prescribed medication.
Length of time order is valid (may not exceed school year)_____

Signature of Physician_____
Telephone Number _____ Fax_____ Date_____

Part II - To be completed by student's parent/ guardian
I hereby request self- administration privileges for my child_____
He/she will demonstrate proper knowledge in the use of the prescribed medication properly. The student will report to the school nurse after the use of the medication during the school day. I also understand that Red Bank Catholic and its employees or agents shall incur no liability as a result of injury arising from the self- administration of medication by student.

_____ _____
Signature of parent/guardian Date

**** Only inhalers and EpiPens may be carried/ self- administered.**

All other medications must be stored and dispensed through the nurse's office**

RED BANK CATHOLIC HIGH SCHOOL
112 BROAD STREET RED BANK , NJ 07701 732 747 1774 FAX 732 747 1936