Admission Physical Packet Information:

- Enclosed please find the Admission Physical Packet required for admission.
- Remove this cover letter and complete the first page before taking the form to the doctor.
- Since a current physical is required for admission, the "Date of Exam" must be after August 11, 2024, to meet the admission requirements. All others will be returned.
- Also in this packet is the Asthma Treatment Plan and Allergy Emergency Treatment. If either of these apply to your child, follow the directions below.
 - If your child has an inhaler, an additional form is required. The inhaler form must be filled out by your student's doctor. Doctor and parent signatures are required on bottom of the form. Return the inhaler form with your student's physical.
 - O If your child has an EPI pen, an additional form is required. Have the doctor fill out and sign the form. Parent signature is also required on the reverse side under the "May Self-Administer" section and where the student's information is located. Return the form with our physical. Please bring the Epi pen and Benadryl to school on the first day of school.
- The completed original physical form packet (the only acceptable form) and medication form, if applicable, must be returned to SJV by the first week of May 2025 – no faxes, copies or other forms are allowed.
- Please make a copy for your own records.

This form should be maintained by the healthcare provider completing the physical exam (medical home). It should not be shared with schools. The medical eligibility form is the only form that should be submitted to a school. The physical exam must be completed by a healthcare provider who is a licensed physician, advanced practice nurse or physician assistant who has completed the Student-Athlete Cardiac Assessment Professional Development module hosted by the New Jersey Department of Education.

PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

MIDIUKT FUKIK						
Note: Complete and sign this form (with your pare	ents if younger than 1	8) before your ap	pointment.			
Name:		Da	te of birth:			
Date of examination:	· ·					
Sex assigned at birth (F, M, or intersex):	. How do you identif	y your gender? (F, i	M, non-binary, or anoth	er gender):		
Have you had COVID-19? (check one): □ Y						
Have you been immunized for COVID-19? (check one): □ Y □ N If yes, have you had: □ One shot □ Two shots □ Three shots □ Booster date(s)						
List past and current medical conditions.						
Have you ever had surgery? If yes, list all past sur	gical procedures					
Medicines and supplements: List all current preso	criptions, over-the-cou	unter medicines, a	nd supplements (herbal	and nutritional).		
Do you have any allergies? If yes, please list all y	your allergies (ie, me	dicines, pollens, fo	ood, stinging insects).			
Patient Health Questionnaire Version 4 (PHQ-4) Over the last 2 weeks, how often have you been	bothered by any of i	the following prob	lems? (Circle response.,			
, and the second se		= *	Over half the days			
Feeling nervous, anxious, or on edge	0	1	2	3		
Not being able to stop or control worrying	0	1	2	3		
Little interest or pleasure in doing things	0	1	2	3		
Feeling down, depressed, or hopeless	0	1	2	3		
(A sum of ≥3 is considered positive on either	er subscale [question	s 1 and 2, or ques	tions 3 and 4] for scree	ening purposes.)		

(E),(p)	IERAL QUESTIONS lain "Yes" answers at the end of this form. Circle stions it you don't know the answer.)	Yes	No
1.	Do you have any concerns that you would like to discuss with your provider?		
2.	Has a provider ever denied or restricted your participation in sports for any reason?		
3.	Do you have any ongoing medical issues or recent illness?		
HIEA	RT HEALTH QUESTIONS ABOUT YOU	Yes	No
4.	Have you ever passed out or nearly passed out during or after exercise?		
5.	Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6.	Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7.	Has a doctor ever told you that you have any heart problems?		
8.	Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

	and 2, or questions 3 and 4] for screening	porpos					
190055555	ART HEALTH QUESTIONS ABOUT YOU NTINUED)		<u> </u>	No.			
9. Do you get light-headed or feel shorter of breath than your friends during exercise?							
10.	Have you ever had a seizure?						
FJEA	RT HEALTH QUESTIONS ABOUT YOUR FAMILY	Unsure	Yes	No			
11.	Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?						
12.	Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?						
13.	Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?						

0	JE AND JOINT QUESTIONS	Yes No	1/(25)(@A) (@
14.	Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		25. Do you 26. Are yo you go
15.	Do you have a bone, muscle, ligament, or joint injury that bothers you?		27. Are yo
NE R	ICAL QUESTIONS	Yes Na	28. Have
16.	Do you cough, wheeze, or have difficulty breathing during or after exercise?		MENSTRUA 29. Have
1 <i>7</i> .	Are you missing a kidney, an eye, a testicle, your spleen, or any other organ?		30. How o
18.	Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		31. When 32. How n
19.	Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant <i>Staphylococcus aureus</i> (MRSA)?		month Explain "Y
20.	Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21.	Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22.	Have you ever become ill while exercising in the heat?		
23.	Do you or does someone in your family have sickle cell trait or disease?		
24.	Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (CONTINUED)							
25. Do you worry about your weight?							
26. Are you trying to or has anyone recommended that you gain or lose weight?							
27. Are you on a special diet or do you avoid certain types of foods or food groups?							
28. Have you ever had an eating disorder?							
MENSTRUAL QUESTIONS N/A							
29.	29. Have you ever had a menstrual period?						
30. How old were you when you had your first menstrual period?							
31. When was your most recent menstrual period?							
32.	How many periods have you had in the past 12 months?						

Explain "Yes" answers here.						

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete:
Signature of parent or guardian:
Date:

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This form should be maintained by the healthcare provider completing the physical exam (medical home). It should not be shared with schools. The Medical Eligibility Form is the only form that should be submitted to a school.

■ PREPARTICIPATION PHYSICAL EVALUATION ATHLETES WITH DISABILITIES FORM: SUPPLEMENT TO THE ATHLETE HISTORY

Name: Date of birth:		
Name:Date of birth:		
I. Type of disability:		
2. Date of disability:		
3. Classification (if available):		
4. Cause of disability (birth, disease, injury, or other):	***************************************	·····
5. List the sports you are playing:		
	Yes	No
6. Do you regularly use a brace, an assistive device, or a prosthetic device for daily activities?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or 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 as having 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.	L	
Explain 163 dilawers nere.		
Please indicate whether you have ever had any of the following conditions:		
	Yes	Ne
Atlantoaxial instability		
Radiographic (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 questions on this form are complete and	correc	t.
Signature of athlete:		
Signature of parent or guardian:		
Date:		

This form should be maintained by the healthcare provider completing the physical exam (medical home). It should not be shared with schools. The medical eligibility form is the only form that should be submitted to a school. The physical exam must be completed by a healthcare provider who is a licensed physician, advanced practice nurse or physician assistant who has completed the Student - Athlete Cardiac Assessment Professional Development module Hosted by the New Jersey Department of Education.

١	Name:			Date of birth:	
Section 2	PHYSICAL EXAMINAT	ION FORM			
	B PKEPARIICIPATION	(PHYSICAL EVALU)	AIION (Interim	Guidance)	

PHYSICIAN REMINDERS

- 1. 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, e-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-enhancing 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?

2. Consider	reviewing que	estions	on cardiova	scular sympt	oms (Q4-Q13 of	f History Fo	rm).				
EXAMINATIO)Ŋ						100 mm				12.00
Height:			Weight:								
BP: /	(/	}	Pulse:		Vision: R 20/		L 20/	Correc	ted:	□Y	□N
@@\\\\\ @@\\\\	4CdM <u>ŧ</u>										
Previously rec	eived COVID-	19 vc	accine: 🗆 Y	$\square N$							
	COVID-19 va	ccine	at this visit:	OY ON	lf yes: □ First	dose 🗆 Se	econd dose	□ Third do			
MEDICAL									No	RMAL	ABNORMAL FINDINGS
Appearance Marfan sti myopia, n	gmata (kypho nitral valve pro	scolio dapse	osis, high-arcl e [MVP], and	ned palate, p aortic insuffi	pectus excavatum ciency)	, arachnodo	actyly, hyper	laxity,	·		
Eyes, ears, no Pupils equ Hearing		t									
Lymph nodes					·						
Heart ^a • Murmurs (auscultation st	tandir	ng, auscultati	on supine, ai	nd ± Valsalva ma	neuver)					
Lungs											
Abdomen											
tinea corp		SV), le	esions sugges	tive of methi	cillin-resistant Sta	phylococcu	s aureus (Mi	RSA), or			
Neurological						×			John Stranger		
Witzenfezie	E ETAL								1/10	RMAL	SOMIDME JAMSONSA
Neck											
Back									<u> </u>		
Shoulder and				***************************************					<u> </u>		
Elbow and for					***************************************				<u> </u>		
Wrist, hand, o									<u> </u>		
Hip and thigh Knee											
Leg and ankle											
Foot and toes	;								_		
Functional	g squat test, sir	ngle-l	eg squat test,	and box dra	op or step drop te	est					
nation of thos	e.					ologist for c	bnormal ca	rdiac histo	ry or	exami	nation findings, or a combi-
Name of health	ı care professi	onal ((print or type):							rte:
Address:	lil r		. 1					Ph	one:		14D DO ND - D

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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	at Athlete's Name	Date of Birth
Date of	f Exam	
0	Medically eligible for all sports without restriction	
0	Medically eligible for all sports without restriction with rec	ommendations for further evaluation or treatment of
0	Medically eligible for certain sports	
0	Not medically eligible pending further evaluation	
0	Not medically eligible for any sports	
Recomr	nmendations:	
athlete of the physicandition	e does not have apparent clinical contraindications to practice a ysical examination findings- are on record in my office and car	this form and completed the preparticipation physical evaluation. The nd can participate in the sport(s) as outlined on this form. A copy of a be made available to the school at the request of the parents. If the physician may rescind the medical eligibility until the problem is the athlete (and parents or guardians).
Signatur	ure of physician, APN, PA	
Address	SS:	. :
Name o	of healthcare professional (print)	_
I certify Education	fy I have completed the Cardiac Assessment Professional Deve tion.	lopment Module developed by the New Jersey Department of
Signatur	ure of healthcare provider	
	Shared Heal	th Information
Allergie	ies	
Medicat	ations:	
Other info	formation:	
Emergency	ncy Contacts:	

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A yearly eye exam to assess visual acuity is required. This is a routine part of a complete physical examination and should be completed by your child's physician upon his/her scheduled well visit. If your child wears glasses or contact lenses, be sure your eye doctor records the visual acuity section on the physical examination form (page 3).

NO CHILD WILL BE CLEARED FOR SPORTS WITHOUT A VISION TEST.

	A	
en e		

FRESERVED FOR SCHOOL DISTRICT USE NOTE: N.J.A.C. 6A:16-2.2 requires the school physician to provide written notification to the parent/legal guardian stating approval or disapproval of the student's participation in athletics based on this physical evaluation. This evaluation and the notification letter become part of the student's school health record. History and Physical Reviewed By: ____ School Physician Title of Reviewer (please check one): School Nurse Medical Eligibility Notification Sent to Parent/Guardian by School Physician Date: Letter of notification is attached. OR Parent notification indicates that: Participation Approved without limitations Participation Approved with limitations pending evaluation Participation NOT Approved

*

Reason(s) for Disapproval;

ı

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









(Please Pri	mt)						
Name				Date of Birth		Effective Date	
Doctor			Parent/Guardian (if	applicable)	Emer	gency Contact	
Phone		Phone	Phone		Phone		
	(Green Zone)		Take daily control more effective wit	th a "spacer" – u	se if dire	ected.	Triggers Check all items that trigger
	Breathing is good No cough or wheeze Sleep through the night Can work, exercise, and play		Advair® HFA 45, 115, Advair® HFA 45, 115, Aerospan™	230 2 p	uffs twice a d 1, □ 2 puffs t 1, □ 2 puffs t uffs twice a d uffs twice a d 1, □ 2 puffs t 1, □ 2 puffs t halation twic 1, □ 2 inhalati halation twic 1, □ 2 inhalati nit nebulized [wice a day wice a day ay wice a day wice a day e a day ons once or twice a day e a day	patient's asthma: Colds/flu Exercise Allergens Dust Mites, dust, stuffed animals, carpet Pollen - trees, grass, weeds Mold Pets - animal dander Pests - rodents, cockroaches
And/or Peak f	flow above] Other] None		_		Odors (Irritants) Cigarette smoke
	If exercise trigge	rs your a				king inhaled medicine. nutes before exercise.	Perfumes,
If quick-relief me 15-20 minutes or 2 times and sym doctor or go to the And/or Peak flo		hin an	Nopenex® (Levalbuterol) □ 0.3 Combivent Respimat® Increase the dose of, or add: Other If quick-relief med week, except before	HOW MUCH to ta Proventil® or Ventolin®) _2 2 31,	ke and HOW 2 puffs every 2 puffs every 1 unit nebulize 1 unit nebulize 1 unit nebulize 1 inhalation 4 more then call y	4 hours as needed 4 hours as needed d every 4 hours as needed times a day an 2 times a your doctor.	cleaning products, scented products Smoke from burning wood, inside or outside Weather Sudden temperature change Extreme weather hot and cold Ozone alert days Foods:
And/or Peak flow below	Your asthma is getting worse fas • Quick-relief medicin not help within 15-20 • Breathing is hard or • Nose opens wide • F • Trouble walking and • Lips blue • Fingerna • Other:	t: e did O minutes fast kibs show I talking ills blue	Take these n Asthma can be a MEDICINE Albuterol MDI (Pro-air® Xopenex® Duoneb® Xopenex® (Levalbuterol) Combivent Respimat® Other	HOW MUC or Proventil® or Ventolin® 5 mg	H to take and a puffs 4 puffs 1 unit number	Do not wait! d HOW OFTEN to take it every 20 minutes every 20 minutes ebulized every 20 minutes ebulized every 20 minutes ebulized every 20 minutes ebulized every 20 minutes	Other: This asthma treatment plan is meant to assist, not replace, the clinical decision-making required to meet individual patient needs
Dealloss of their letters and it distilled of children letters. All their letters are consistent of combination and All Mark has no request relies to the exterior state. All Mark has no request relies to the exterior state. All their letters are relied to the exterior state. The state of their letters are relied to the exterior state. The state of their letters are relied to their letters are relied to the exterior state. The state of their letters are relied to the exterior state of their letters are relied to the exterior state. The state of their letters are relied to the exterior state of their letters are relied to their letters. The state of their letters are relied to the exterior state of their letters are relied to the exterior state. The state of their letters are relied to the letters are relied to the exterior state. The state of their letters are relied to the letters are relied to the exterior state. The state of their letters are relied to the letters are relied to the exterior state. The state of their letters are relied to the exterior state of the exteri	merrine, upon se inspired, discharge en denselle, serderling bei nor interpresent of the position, but eithers has predict protection. As matter, and could be comprisented, prosper, of involvers of the could have been also an either the could be an either that the position in the comprisent production and protection of the last gradies, or an entire production of the industrial interpretation of last gradies, or an entire production of the industrial interpretation of last gradies, or an entire production of the industrial interpretation of last gradies, and entire production of the industrial industrial and of the entirely design of the industrial industrial industrial and of the entirely design of the industrial industrial industrial mental collection of the industrial	This stu in the pi non-net in accor	on to Self-administer Medicati dent is capable and has been instruc- roper method of self-administering of ulized inhaled medications named all dance with NJ Law.	of the bove PARENT/GUARDIAN S	SIGNATURE	Physician's Orders	Date

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

- · Child's date of birth
- An Emergency Contact person's name & phone number
- & 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
 - <u>Permission to Self-administer Medication</u> 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 medi in its original prescription container properly labele information between the school nurse and my chi understand that this information will be shared with statements.	d by a pharmacist or physician ld's health care provider conce	n. I also give permission for the erning my child's health and n	e release and exchange of
Parent/Guardian Signature	Phone		Date
FILL OUT THE SECTION BELOW ONLY IF YOUR HE SELF-ADMINISTER ASTHMA MEDICATION ON THI RECOMMENDATIONS ARE EFFECTIVE FOR ONE (FRONT OF THIS FORM.		
I do request that my child be ALLOWED to carry the following medication			
☐ I DO NOT request that my child self-administer	nis/her asthma medication.		•
Parent/Guardian Signature	Phone		Date



Disclaimers: The use of this Website/PACNU Ashhma Treatment Plan and its content is all your own risk. The content is provided on an "as is" basis. The American Lung Association of the Mid-Allantic (ALAM-A), the Peciatric/Adult Ashrma Coatificion of level desires and all infliated sclatchin all warranties, somes or implied, statutory or otherwise, including but not limited to the implied wernanties or merchantability, non-infringement of third granter inglist, and fitness for a paramited propose. ALAM-A makes no representations or warranties so the accuracy reliability, completies, currency or financies of the content, LAAM-A makes no versament, presentation for our quarranty that their formation will be unintenrupted or error free or that any defects can be curreded, in no event stall ALAM-A be liable for any damages, currency or financies or warranty, because of content, and consequential damages, personal injury/wrongful destination, or daze no becauses interruption; leveling from the use or becauses interruption; leveling from the use or content of this Admandant Plan whether lessed or warranty, because, of content, and for any damage or content of this Admandant Plan whether lessed or warranty, becomes, or levels, 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, what soever, caused by your use or misuse of the Asthma Treatment Plan, nor of this websile.



1

Saint John Vianney High School

PHYSICIAN'S ORDERS FOR ALLERGY EMERGENCY TREATMENT

Student's name	Birth date	Grade
The above student is allergic to:		
Previous episode of anaphylaxis	Yes No	
MEDICATIONS ANTIHISTAMINE: Name	· · · · · · · · · · · · · · · · · · ·	Dose
Give antihistamine for the following	checked symptoms:	*
Contact with altergen, but no synthesis Skin – hives, itchy rash, extremity Lips – itching, tingling, burning, of Head/neck – swelling of tongue, Gut – abdominal cramps, nausea Lungs – repetitive cough, wheezi Heart – thready pulse, low blood Other	y swelling or swelling of lips mouth, or throat, hoa a, vomiting, diarrhea ing, shortness of brea	
EPINEPHRINE: EpiPen E	oiPen Jr. □Other	Control of the second of the s
Give Epinephrine for the following cl	necked symptoms:	
Contact with allergen, but no synthesis Skin – hives, itchy rash, extremity Lips – itching, fingling, burning, contact – swelling of tongue, Gut – abdominal cramps, nauses Lungs – repetitive cough, wheez Heart – thready pulse, low blood Other	y swelling or swelling of lips mouth, or throat, hoa a, vomiting, diarrhea ing, shortness of brea pressure, fainting, pa	ath
Choose one administration order: Give Antihistamine only Give Antihistamine & Epinephrine at Give Antihistamine first, observe for *Please note- in the absence of a antihistamine order will be disreg	Give epinephrine same time \square *De further symptoms an school nurse, a trai	only *Delegate will be assigned elegate will be assigned
☐ This student has been trained an named above. ☐ Epinephrine – single	id is capable of self-a gle dose unit ☐ E	administration of the following medication(s) pinephrine & antihistamine – single dose units
*Under NJ state law, orders for antif	nistamine alone cann	not be self administered
☐ This student is not capable of se	lf-administration of th	ne medications named above.
Physician's signature		
Phone number		
Date	St	tamp



Parents/Guardians

A current single dose Epinephrine auto-injector must be provided to the school for your child's use All Antibistamines and Epinephrine must be brought to school by an adult and be provided in the original container.

has a potentially life threatening illness and is unable to self-administer the prescribed medication in a life threatening eliuation. I hereby request the school nurse or delegate (if applicable) to administer the prescribed medication to my child. I further acknowledge that the School shall incur no liability as a result of any injury arising rom administration of the medication to my child. If procedures specified by NJ law and School collect are followed. I shall indemnify and hold harmless the School and it's employees or agents against any claims arising out of administration of medication to my child. Eignature of Parent/Guardian Date Please sign below: I understand that under NJ state law (P.L. 1997, c368 (c.18a:40-12.5)), a trained delegate will be assigned to administer epinephrine to my child in the absence of a school nurse. In the absence of a school nurse, any antihistamine order will be disregarded and epinephrine will be	Parents, Select ONLY ONE (1) OR 1	TWO (2) to si	gn and date:	
(2) May Not Self-Administer I verify that my child Inable to self-administer the prescribed medication in a life threatening situation. I hereby request the school nurse or delegate (if applicable) to administer the prescribed medication to my child. I further acknowledge that the School shall incur no liability as a result of any injury arising rom administration of the medication to my child. I firefore the prescribed medication to my child. I for the prescribed medication to my child. I for the prescribed medication to my child. I for the prescribed medication of my child. I shall indemnify and hold harmless the School and it's employees or agents any claims arising out of administration of medication to my child. Signature of Parent/Guardian Date Please sign below: I urriderstand that under NJ state law (P.L. 1997, c368 (c.18a:40-12.5)), a trained delegate will be assigned to administer epinephrine to my child in the absence of a school nurse. In the absence of a school nurse, any antihistamine order will be disregarded and epinephrine will be administered by a trained delegate. The Trained Delegates are: 1. **Little Author Herman Research Standard Arternation of the property of the pr	I verify that my child and has been instructed in self-adminissituation. I hereby give permission for my further acknowledge that result of any injury arising from the self-admispecified by NJ law and School policy are found it's employees or agents against any cl	tration of the p y child to self- ninistration of m ollowed, I shall	rescribed medication in a administer prescribed in School shall incur nedication by my shild. If pilotomic and hold harmle	life threatening edication. I collection I c
has a potentially life threatening illness and is unable to self-administer the prescribed medication in a life threatening eliuation. I hereby request the school nurse or delegate (if applicable) to administer the prescribed medication to my child. I further acknowledge that the School shall incur no illability as a result of any injury arising rom administration of the medication to my child. If procedures specified by NJ law and School collection are followed. I shall indemnify and hold harmless the School and it's employees or agents against any claims arising out of administration of medication to my child. Signature of Parent/Guardian Date Please sign below: I understand that under NJ state law (P.L. 1997, c368 (c. 18a:40-12.5)), a trained delegate will be assigned to administer epinephrine to my child in the absence of a school nurse. In the absence of a school nurse, any antihistamine order will be disregarded and epinephrine will be administered by a trained delegate. The Trained Delegates are: 1. **Luck out Muttal Mark** 3. **New Mark of Mar	Signature of Parent/Guardian	<u>OR</u>	, Date	
Please sign below: I understand that under NJ state law (P.L.1997, c368 (c.18a:40-12.5)), a trained delegate will be assigned to administer epinephrine to my child in the absence of a school nurse. In the absence of a school nurse, any antihistamine order will be disregarded and epinephrine will be administered by a trained delegate. The Trained Delegates are: 1. KALLOUNDER ONTILO 2. Gabrielle Tontilo 4.	request the school nurse or delegate (If applichtld. I further acknowledge that the School reference to my defending to my decision to my defended to the modern of the medication to my defended to the modern of t	edication in a li leable) to admir shall incur no ils child, if procedu d harmless the	fe threatening alluation. I I nister the prescribed medic ability as a result of any inj res specified by NJ law ar School and it's employees	nereby catlon to my ury arlsing nd School
I understand that under NJ state law (P.L. 1997, c368 (c. 18a: 40-12.5)), a trained delegate will be assigned to administer epinephrine to my child in the absence of a school nurse. In the absence of a school nurse, any antihistamine order will be disregarded and epinephrine will be administered by a trained delegate. The Trained Delegates are: 1. KALL QUIN HUTSAK ATC 3. NEYENNE BENNET. 2. (7abrielle Tontilo 4.	ignature of Parent/Guardian		Date	
Parent Signature c Date	I understand that under NJ state law (P.L.18 assigned to administer epinephrine to my chabsence of a school nume, any antihistamine administered by a trained delegate. The Trained Authority ATC (Abrille Tontillo	nlld in the abse se order will be alned Delegate	nce of a school nurse. I disregarded and epinephri as are: NEYENNE BENNE	n the
	Parent Signature c		Date	

SEIZURE ACTION PLAN (SAP)

How to give __



ENDEPILEPSY"

Name:	Birth Date:		
Address:	Phone:		
Emergency Contact/Relationship	Phone:		
Seizure Information			
Seizure Type How Long It Lasts How	Often What Happens		
3690 - 792730 - 73 10 - 10 10 10 10 10 10 10 10 10 10 10 10 10			
How to respond to a seizure (check	k all that apply) 🗹		
☐ First aid – Stay. Safe, Side.	□ Notify emergency contact at		
☐ Give rescue therapy according to SAP	☐ Call 911 for transport to		
☐ Notify emergency contact			
	Other		
First aid for any seizure	When to call 911		
•	Seizure with loss of consciousness longer than 5 minutes,		
STAY calm, keep calm, begin timing seizure	not responding to rescue med if available		
 Keep me SAFE – remove harmful objects, don't restrain, protect head 	Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med if available		
SIDE – turn on side if not awake, keep airway clear,	☐ Difficulty breathing after seizure		
don't put objects in mouth	☐ Serious injury occurs or suspected, seizure in water		
STAY until recovered from seizure	When to call your provider first		
Swipe magnet for VNS	☐ Change in seizure type, number or pattern		
☐ Write down what happens	Person does not return to usual behavior (i.e., confused for a long period)		
Other	☐ First time seizure that stops on its' own		
	☐ Other medical problems or pregnancy need to be checked		
When rescue therapy may be	needed:		
WHEN AND WHAT TO DO			
If seizure (cluster, # or length)			
Name of Med/Rx			
How to give			
If seizure (cluster, # or length)			
	How much to give (dose)		
-			
If seizure (cluster, # or length)			
Name of Med/Rx	How much to give (dose)		

Seizure Action Plan continued	
Care after seizure What type of help is needed? (describe)	· · · · · · · · · · · · · · · · · · ·
When is person able to resume usual activ	vity?
Special instructions	
First Responders:	
Emergency Department:	
Daily seizure medicine	
Medicine Name Total Daily Amo	unt Amount of How Taken Tab/Liquid (time of each dose and how much)
Other information Triggers:	
Important Medical History	
Allergies	
	planted
	C ☐ Modified Atkins ☐ Other (describe)
Health care contacts	
Epilepsy Provider:	Phone:
Primary Care:	Phone:
Preferred Hospital:	Phone:
	Phone:
My signature	Date
Provider signature	Date





