MENDHAM TOWNSHIP SCHOOLS
PHYSICAL EXAMINATION/IMMUNIZATION RECORD

Child's name (last)__________________(first)___________________B.D.__________Sex_____

Height________Weight________Date Of Examination________________________

CHECK IF THERE IS A PROBLEM/ABNORMALITY

Nose________________ Spine____________Lungs
Throat___________ Chest___________ Gums/teeth_______
Abdomen________ Genitals________ Glands__________
Nutrition_______
Blood pressure________Heart________ ___________
Healthy child? Yes_______ No ______

Vision Glasses
near______ yes______
far_______ no______

Hearing
right______
left _______

Feet_________ Skin

Allergies ____
Required Daily Medications_______________________________________
Special Problems/Physical Restrictions______________________________
Student may participate fully in all school programs including Physical Ed.______

IMMUNIZATIONS	DATES	IMMUNIZATIONS	DATES
*DPT 1	______	POLIO—(OPV) OR(IPV)	
*DPT 2	______	(TYPE)	
*DPT 3	______	*1_________	______
*DPT/DTaP 4	______	*2_________	______
*DTP/DTaP 5	______	*3_________	______
(on or after 4th birthday)		*4_________	______
		(On or after 4th birthday)	
MMR# 1	______		
*(on or after first birthday)		* HIB ________2________3_________	
MMR# 2		4________5________	
*(on or after fourth birthday)	______		
		*Varicella #1_________#2_________	
Tuberculin Test:			
(Type) Mantoux____Tine____	______	* HBV	
(result) __________________		#1______#2_______#3________	
Meningococcal ____ ____ ____ ____		Pneumococcal _____ _____ ______	
____ ____ ____ ____		_____ _____ ______	
Hepatitis A _____ _____			

*

____
Physicians signature

***Required by NJ State Law to enter Kindergarten**

See school nurse for medical or religious exemptions

NAME:____________________________ (To be filled out by parent)

CHILD'S HEALTH HISTORY

PRENATAL AND BIRTH HISTORY

Problems during pregnancy_____________________________Full term?____________
Length of labor________Type of delivery: normal, forceps, caesarean
Condition at birth: normal_____jaundiced ________, cyanotic_________
Birth weight_____________

***DEVELOPMENTAL HISTORY:** Please record any developmental problems (i.e. delayed speech, poor coordination)*

____

____

***MEDICAL HISTORY:** Please check and include dates if possible.*

Communicable diseases: Chicken pox__________ Scarlet fever____________________
Measles__________________ Mumps_____________
Other Illnesses: Strep infections________, Tonsillitis________, Lyme Disease _______
Frequent colds__________, ear infections____________, other______________________
Surgical procedures:____

____
Injuries: (i.e. fractures concussions)____
Physical limitations: ____
Allergies: ____
Deficiencies: Vision______, Hearing________, Speech__________________________
Eyes examined by an eye specialist? __________ If so, when______________________
Wearing glasses?______________________
Date of most recent dental check-up ______________Dentist Name_________________

HEALTH HABITS: Please check any that cause parental concern:
Elimination______, Bedwetting______Diet_______________Appetite______________
Fears__________Peer relations____
Sibling rivalry___________________Temper tantrums__________________________
Sleep______________________Other____
Indicate # of hours sleep averaged per night____________________

MEDICATIONS: Does your child take daily medications?________
If so, please list: ____

I give the school nurse permission to share pertinent health information with other essential staff members when it is necessary to assist in meeting the health and educational needs of my child.

Signature of Parent or Guardian:____

New Jersey Department of Health
MINIMUM IMMUNIZATION REQUIREMENTS FOR SCHOOL ATTENDANCE IN NEW JERSEY
N.J.A.C. 8:57-4: IMMUNIZATION OF PUPILS IN SCHOOL

Disease(s)	Meets Immunization Requirements	Comments
DTaP//DTP	**Age 1-6 years:** 4 doses, with one dose given on or after the 4th birthday, OR any 5 doses. **Age 7-9 years:** 3 doses of Td or any previously administered combination of DTP, DTaP, and DT to equal 3 doses	Any child entering pre-school, and/or pre-Kindergarten needs a minimum of 4 doses. A booster dose is needed on or after the fourth birthday, to be in compliance with Kindergarten attendance requirements. Pupils after the seventh birthday should receive adult type Td. Please note: there is no acceptable titer test for pertussis.
Tdap	**Grade 6** (or comparable age level for special education programs): 1 dose	For pupils entering Grade 6 on or after 9-1-08 and born on or after 1-1-97. A child is not required to have a Tdap dose until FIVE years after the last DTP/DTaP or Td dose.
Polio	**Age 1-6 years**: 3 doses, with one dose given on or after the 4th birthday, OR any 4 doses. **Age 7 or Older:** Any 3 doses	Any child entering pre-school, and/or pre-Kindergarten needs a minimum of 3 doses. A booster dose is needed on or after the fourth birthday to be in compliance with Kindergarten attendance requirements. Either Inactivated polio vaccine (IPV) or oral polio vaccine (OPV) separately or in combination is acceptable. Polio vaccine is not required of pupils 18 years or older.*
Measles	If born before 1-1-90, 1 dose of a live measles-containing vaccine on or after the first birthday. If born on or after 1-1-90, 2 doses of a live measles-containing vaccine on or after the first birthday.	Any child over 15 months of age entering child care, pre-school, or pre-Kindergarten needs a minimum of 1 dose of measles vaccine. Any child entering Kindergarten needs 2 doses. Intervals between first and second measles-containing vaccine doses cannot be less than 1 month. Laboratory evidence of immunity is acceptable.**
Rubella and Mumps	1 dose of live mumps-containing vaccine on or after the first birthday. 1 dose of live rubella-containing vaccine on or after the first birthday	Any child over 15 months of age entering child care, pre-school, or pre-Kindergarten needs 1 dose of rubella and mumps vaccine. Any child entering Kindergarten needs 1 dose each. Laboratory evidence of immunity is acceptable. **
Varicella	1 dose on or after the first birthday	All children 19 months of age and older enrolled into a child care/pre-school center after 9-1-04 or children born on or after 1-1-98 entering the school for the first time in Kindergarten or Grade 1 need 1 dose of varicella vaccine. Laboratory evidence of immunity, physician's statement or a parental statement of previous varicella disease is acceptable.
Haemophilus influenzae B (Hib)	**Age 2-11 Months**: 2 doses **Age 12-59 Months**: 1 dose	Mandated only for children enrolled in child care, pre-school, or pre-Kindergarten: Minimum of 2 doses of Hib-containing vaccine is needed if between the ages of 2-11 months. Minimum of 1 dose of Hib-containing vaccine is needed after the first birthday. ***
Hepatitis B	**K-Grade 12**: 3 doses or **Age 11-15 years**: 2 doses	If a child is between 11-15 years of age and has not received 3 prior doses of Hepatitis B then the child is eligible to receive 2-dose Hepatitis B Adolescent formulation.
Pneumococcal	**Age 2-11 months**: 2 doses **Age 12-59 months**: 1 dose	Mandated only for children enrolled in child care, pre-school, or pre-Kindergarten: Minimum of 2 doses of pneumococcal conjugate vaccine is needed if between the ages of 2-11 months. Minimum of 1 dose of pneumococcal conjugate vaccine is needed after the first birthday. ***
Meningococcal	Entering Grade 6 (or comparable age level for Special Ed programs): 1 dose	For pupils entering Grade 6 on or after 9-1-08 and born on or after 1-1-97. *** This applies to students when they turn 11 years of age and attending Grade 6.
Influenza	**Ages 6-59 Months**: 1 dose annually	For children enrolled in child care, pre-school, or pre-Kindergarten on or after 9-1-08. 1 dose to be given between September 1 and December 31 of each year. Students entering school after December 31 up until March 31 must receive 1 dose since it is still flu season during this time period.

New Jersey Department of Health

MINIMUM IMMUNIZATION REQUIREMENTS FOR SCHOOL ATTENDANCE IN NEW JERSEY
N.J.A.C. 8:57-4: IMMUNIZATION OF PUPILS IN SCHOOL

*** Footnote**: The requirement to receive a school entry booster dose of DTP or DTaP after the child's 4th birthday shall not apply to children while in child care centers, preschool or pre-kindergarten classes or programs.

The requirement to receive a school entry dose of OPV or IPV after the child's 4th birthday shall not apply to children while in child care centers, preschool or pre-kindergarten classes or programs.

**** Footnote**: Antibody Titer Law (Holly's Law)—This law specifies that a titer test demonstrating immunity be accepted in lieu of receiving the second dose of measles-containing vaccine. The tests used to document immunity must be approved by the U.S. Food and Drug Administration (FDA) for this purpose and performed by a laboratory that is CLIA certified.

***** Footnote**: No acceptable immunity tests currently exist for Haemophilus Influenzae type B, Pneumococcal, and Meningococcal.

Please Note The Following:

The specific vaccines and the number of doses required are intended to establish the minimum vaccine requirements for child-care center, preschool, or school entry and attendance in New Jersey. These intervals are not based on the allotted time to receive vaccinations. The intervals indicate the vaccine doses needed at earliest age at school entry. Additional vaccines, vaccine doses, and proper spacing between vaccine doses are recommended by the Department in accordance with the guidelines of the American Academy of Pediatrics (AAP) and Advisory Committee on Immunization Practices (ACIP), as periodically revised, for optimal protection and additional vaccines or vaccine doses may be administered, although they are not required for school attendance unless otherwise specified.

Serologic evidence of immunity (titer testing) is only accepted as proof of immunity when no vaccination documentation can be provided or prior history is questionable. It cannot be used in lieu of receiving the full recommended vaccinations.

Provisional Admission:
Provisional admission allows a child to enter/attend school after having received a minimum of one dose of each of the required vaccines. Pupils must be actively in the process of completing the series. Pupils <5 years of age, must receive the required vaccines within 17 months in accordance with the ACIP recommended minimum vaccination interval schedule. Pupils 5 years of age and older, must receive the required vaccines within 12 months in accordance with the ACIP recommended minimum vaccination interval schedule.

Grace Periods:

- 4-day grace period: All vaccine doses administered less than or equal to four days before either the specified minimum age or dose spacing interval shall be counted as valid and shall not require revaccination in order to enter or remain in a school, pre-school, or child care facility.
- 30-day grace period: Those children transferring into a New Jersey school, pre-school, or child care center from out of state/out of country may be allowed a 30-day grace period in order to obtain past immunization documentation before provisional status shall begin.

MENDHAM TOWNSHIP SCHOOL DISTRICT EMERGENCY CARD 2015-2016

Student's Name__________________________________Grade______Homeroom____________

Home/Mailing Address________________________________Home Phone____________________
With whom does the student reside?____

Mother's Name		Father's Name	
Cell #		Cell #	
Work #		Work#	
Email address		Email address	

May we share the above information with the H.S.A. for publication in their directory? Yes No
Would you like to receive news from the Mendham Township Education Foundation? Yes No

Please list your three primary emergency contacts <u>in the order you wish them to be called:</u>

NAME	RELATION TO STUDENT	PHONE

HEALTH INFORMATION
List any health concerns or allergies your child has:

____

As parent/guardian of the above named student, I hereby authorize the release of pertinent medical information (ie; conditions, allergies, and treatment regimes) to be exchanged among appropriate professional staff involved in the care of my child. This consent is intended to allow the staff to better serve my child.

Parent/Guardian Signature_______________________________________Date____________________________
If unwilling to document, but have concerns to share with the school nurse, please call.

1. **Is your child covered by Health Insurance? Yes,** name of insurance company____________________________

   No ____ NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information call 800-701-0710 or visit <u>www.njfamilycare.org</u> to apply online. You may release my name and address to NJ FamilyCare Program to contact me about health insurance.

Signature:______________________________**Printed Name:**_________________________**Date:**_______________

....

PERMISSION TO ADMINISTER MEDICATION (includingTylenol/Advil)

List **all medications** that your child is currently taking:

____

If your child needs **Tylenol**__________**Advil**__________do we have your permission to administer? ___ Yes ___ No

Physician____Telephone_____________________
Dentist____Telephone_____________________

In case of emergency, I authorize officials of Mendham Township School District to contact directly the persons named on this form and I authorize the named physicians to render such treatment as deemed necessary. In the event that physicians, other persons named on this form, or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child. I understand that the school officials will first attempt to notify me at the above numbers.

PARENT/GUARDIAN SIGNATURE____________________________________**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 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 ____________________

STUDENT AUTHORIZATION FOR SELF ADMINISTRATION OF ASTHMA MEDICATION

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

Disclaimers: The use of this Website/PACNJ 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 or 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.

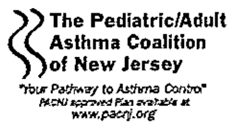
The Pediatric/Adult Asthma Coalition of New Jersey is sponsored by the American Lung Association in New Jersey. This publication was supported by a grant from the New Jersey Department of Health and Senior Services, with funds provided by the U.S. Centers for Disease Control and Prevention under Cooperative Agreement 5U59EH000491-03. 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 XA97250908-4 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.

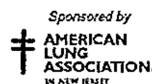
Sponsored by

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)





(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.

[illegible]

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

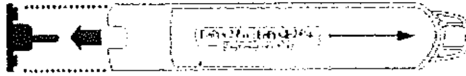
REVISED JULY 2012

Permission to reproduce blank form • www.pacnj.org

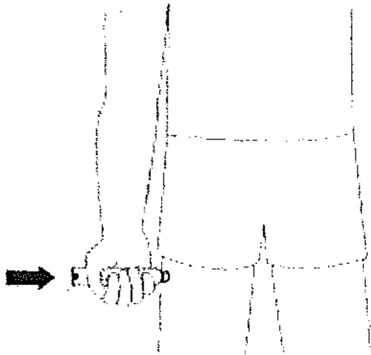
Make a copy for parent and for physician file, send original to school nurse or child care provider.

EpiPen® (epinephrine) Auto-Injector Directions

- First, remove the EpiPen® (epinephrine) Auto-Injector from the plastic carrying case
- Pull off the blue safety release cap



- Hold orange tip near outer thigh (always apply to thigh)



- Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 10 seconds.

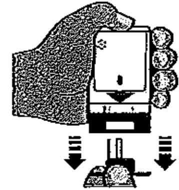
Remove EpiPen® (epinephrine) Auto-Injector and massage the area for 10 more seconds.

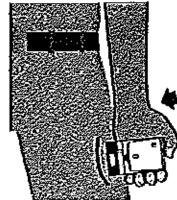
EpiPen®, EpiPen 2-Pak®, and EpiPen Jr 2-Pak® are registered trademarks of Mylan Inc. licensed exclusively to its wholly-owned subsidiary, Mylan Specialty L.P.

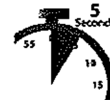
Auvi-Q™ (epinephrine injection, USP) Directions

Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.

Pull off RED safety guard.







Place black end against outer thigh, then press firmly and hold for 5 seconds.

Auvi-Q
epinephrine injection, USP
0.15 mg/0.3 mg auto-injectors

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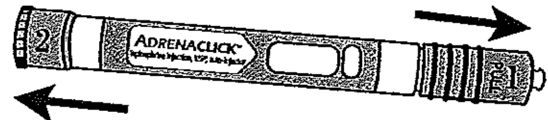
Adrenaclick® 0.3 mg and Adrenaclick® 0.15 mg Directions



Remove GREY caps labeled "1" and "2."

Place RED rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

A food allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student's physician, and a copy of this Food Allergy Action Plan.

A kit must accompany the student if he/she is off school grounds (i.e., field trip).

Contacts

Call 911 • Rescue squad: (____) ____-______ Doctor: ____________________ Phone: (____) ____-______

Parent/Guardian: ____________________________________ Phone: (____) ____-______

Other Emergency Contacts

Name/Relationship: ________________________________ Phone: (____) ____-______

Name/Relationship: ________________________________ Phone: (____) ____-______

MENDHAM TOWNSHIP SCHOOL DISTRICT
HEALTH SERVICES

Joyce Kierst, R.N., M.S.N.
Mendham Twp. Middle School
Certified School Nurse
973-543-2505 ext2
Health Office Fax 973-543-2032

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Mendham Twp. Elementary School
School Nurse
973-543-7107 ext 222
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Emergency Health Care Plan
Life Threatening Allergies

Child's Name ______________________________ DOB __________
Allergy to: ______________________________
Asthmatic: ____ Yes (high risk for severe reaction) ____ No
Student's past symptoms of an allergic reaction: (describe) ______________________________
____

Physician, please circle systems/symptoms that relate to this student.

Systems	Symptoms
Mouth	Itching and swelling of the lips, tongue or mouth
Throat	Itching and/or a sense of tightness in the throat, hoarseness and hacking cough
Skin	Hives, itchy rash and/or swelling about the face and extremities
Gut	Nausea, abdominal cramps, vomiting and/or diarrhea
Lung	Shortness of breath, repetitive coughing, and/or wheezing
Heart	"thread" pulses, "passing out"

The severity of symptoms can quickly change. All above symptoms can potentially progress to a life-threatening situation.

Action:

1. If ingestion (or contact) occurs immediately administer: ______________________________
____
2. Call **911** and have them notify **MICU** (state epinephrine is required)
3. Call Parents/Emergency contacts

- **BY NJ LAW, TRAINED EPINEPHRINE DELEGATE MAY ONLY ADMINISTER EPINEPHRINE AUTO-INJECTION.**

Emergency contacts:

Mother: ____________________ Father: ____________________
Home # ____________________ Home # ____________________
Work # ____________________ Work # ____________________
Cell# ____________________ Cell# ____________________
Other Emergency Contact ____________________ Relation ____________________
Telephone # ______________________________
Doctor: ____________________ Telephone # ____________________

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL FIRST AID RESCUE SQUAD

I ________________ (parent/guardian) of ________________ (student's name) agree to the above stated emergency contacts and district designated delegate(s).

____________________ ____________________
(Parent signature and date) (Doctor signature with date and office stamp and Rx. Epipen)

(CONTINUE ON BACK)

DESIGNATION OF ADMINSTRATION OF EPINEPHRINE
MENDHAM TOWNSHIP SCHOOL DISTRICT

The certified school nurse may designate, in consultation with the building administrator, another employee of the district to administer a pre-filled single dose auto-injector mechanism containing epinephrine when the school nurse is not physically present at the scene, including sponsored after-school activities.

The employees will be trained using the "Training Protocols for the Implementation of Emergency Administration of Epinephrine" issued by the New Jersey Department of Education.

STUDENT NAME: ______________________________ GRADE: ______

A list of employee(s) designated to administer epinephrine for your child in the event the school nurse is not physically present at the scene may be obtained from your building school nurse.

I give consent for the district's designated delegate to administer epinephrine in the event the school nurse is not present at the scene. I understand that the District and its employees or agents shall incur no liability as a result of any injury arising from the administration of a pre-filled single dose auto-injector mechanism containing epinephrine and that I indemnify and hold harmless the District and its employees or agents against claims arising from the administration of a pre-filled single dose auto-injector mechanism containing epinephrine.

______________________________ ______________________

Parent/Guardian Signature Date

Volunteer Trained Epinephrine Delegates **Date**

______________________________ ______________

______________________________ ______________

______________________________ ______________

______________________________ ______________

______________________________ ______________

______________________________ ______________

______________________________ ______________

2013-2014