THE CRAIG SCHOOL
LOWER SCHOOL • MIDDLE SCHOOL
15 Tower Hill Road • Mountain Lakes, NJ 07046 • 973-334-1234 • www.craigschool.org

Back to School Medical Forms 2023-2024

FORMS ARE DUE AUGUST 15th, 2023

Medical Forms must be handed in before laptops are released

☑ ***Checklist: Forms to be filled out and returned***

Health & Medical Forms

- ☐ The Craig School Emergency Form
- ☐ Participation Physical Evaluation - History Form [Parent Signature Required]
- ☐ Physical Examination Form [Physician Signature Required]
- ☐ The Athlete with Special Needs Supplemental Form [Parent Signature Required]
- ☐ Clearance Form [Physician Signature & Stamp Required]
- ☐ State of NJ Health History Form
- ☐ Permission to share medical information
- ☐ NJSIAA Parent/Guardian Concussion Form
- ☐ Sudden Cardiac Death Pamphlet sign off sheet
- ☐ Please include a copy of current immunization records

The following forms must be filled only if applicable

- ☐ Authorization to administer medication (prescription and/or over the counter) by the school nurse
- ☐ Food and Allergy Form
- ☐ Asthma Form

Please make copies for your records, scan or mail the original, signed, and completed forms, with check list, to gbeck@craigschool.org or records@craigschool.org

THE CRAIG SCHOOL EMERGENCY INFORMATION FORM

Student's Name: _____ DOB: _____ Student's Grade: _____

Parent #1: _____ Parent #2: _____

Home Address: _____

Home Phone: _____ Primary Email: _____

Parent #1 Work Phone: _____ Parent #2 Work Phone: _____

Parent #1 Cell Phone: _____ Parent #2 Cell Phone: _____

Contact Person if parents unavailable: _____ Relationship to student: _____

Contact Person Address: _____ Cell Phone #: _____

Doctor's Name: _____ Phone #: _____

Hospital Affiliation: _____ Address: _____

List any and all prescription medications you give to your child including dosages & times: _____

_____

Allergies: _____

Other relevant emergency medical information (e.g. past medical history):

_____

Date of last physical exam: _____

Does this child have any health insurance including NJ Family Care/Medicare, Medicare, private or other?

If YES, name of insurance company: _____

If NO, NJ Family Care provides free or low-cost health insurance for uninsured children and certain low-income parents. For more information call 1-800-701-0710 or visit www.njfamilycare.org to apply online. Craig School may release my name and address to the NJ Family Care Program to contact me about health insurance:

Signature: _____ Printed Name: _____ Date: _____

Written Consent required pursuant to 20 U.S.C. 1232g (b)(1) and 34 C.F.R. 99.30 (b)

***If any information changes during the school year or summer program, please email the office, or send a note.*

In case of medical emergency, I will be called. In the event a parent or guardian cannot be reached, I agree that The Craig School staff will make any medical decision deemed necessary. I agree to assume the financial responsibility for such emergency treatment.

_____ _____ _____

Signature of Parent or Guardian *Printed Name* *Date*

NOTE: THIS FORM MUST BE COMPLETED FOR *ALL* STUDENTS AND RETURNED PRIOR TO THE START OF SCHOOL

ATTENTION PARENT/GUARDIAN: The preparticipation physical examination (page 3) must be completed by a health care provider who has completed the Student-Athlete Cardiac Assessment Professional Development Module.

Preparticipation Physical Evaluation
HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keepa copy of this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ... Asthma ... Anemia ... Diabetes ... Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ High cholesterol ☐ Kawasaki disease ... A heart murmur ... A heart infection Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

_____

_____

_____

_____

_____

_____

_____

_____

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

Signature of athlete _____ Signature of parent/guardian _____ Date _____

HE0503 9-2681/0410

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

Preparticipation Physical Evaluation
THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

1. Type of disability
2. Date of disability
3. Classification (if available)
4. Cause of disability (birth, disease, accident/trauma, other)
5. List the sports you are interested in playing

	Yes	No
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

_____

_____

_____

_____

_____

Please indicate if you have ever had any of the following.

	Yes	No
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers here

_____

_____

_____

_____

_____

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

Signature of athlete _____ Signature of parent/guardian _____ Date _____

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

NOTE: The preparticiaption physical examination must be conducted by a health care provider who 1) is a licensed physician, advanced practice nurse, or physician assistant; and 2) completed the Student-Athlete Cardiac Assessment Professional Development Module.

Preparticipation Physical Evaluation
PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

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, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5-14).

EXAMINATION		
Height Weight ... Male ... Female		
BP / (/) Pulse Vision R 20/ L 20/ Corrected ... Y ... N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart [a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic [c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason _____

Recommendations _____

_____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) (print/type)_____Date of exam _____

Address _____Phone _____

Signature of physician, APN, PA _____

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

■ Preparticipation Physical Evaluation
CLEARANCE FORM

Name _____ Sex ☐ M ☐ F Age _____ Date of birth _____

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason ___

Recommendations _____

EMERGENCY INFORMATION

Allergies _____

Other information _____

HCP OFFICE STAMP

SCHOOL PHYSICIAN:

Reviewed on _____
(Date)

Approved _____ Not Approved _____

Signature: _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) _____ Date _____

Address _____ Phone _____

Signature of physician, APN, PA _____

Completed Cardiac Assessment Professional Development Module

Date _____ Signature _____

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

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PERMISSION TO SHARE MEDICAL INFORMATION

Everyday each student is in contact with a variety of teachers and other staff members. In order to be sure that your child's needs are being met it is sometimes important to share medical information about them with these staff members. This sharing also helps us collaborate effectively with the healthcare professionals who are working with your child. The kinds of information may include: known allergies, special diet or food restrictions, a history of seizures, and medications that are taken routinely. It is especially important that faculty members are aware when there has been a change in medications so that they can share with you and your children's physician any observed changes in behavior.

We are asking our permission to share these kinds of information as we deem necessary. Information may be shared with orally or in writing with those who will be working with your child. Any information that you do not wish to be shared will, ofcourse, be kept confidential.

Child's Name _____

☐ I give permission for medical information about my child to be shared with appropriate staff members with the exceptions listed below:

_____

_____

_____

_____

☐ I ask that no medical information about my child be shared with staff members.

_____ _____

Parent / Guardian Signature **Date**

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 ☐
11. Has any member of the student-athlete's household been diagnosed with Coronavirus (COVID-19)? Yes ☐ No ☐

Date: _____ Signature of parent/guardian: _____

Please Return Completed Form to the School Nurse's Office

1161 Route 130, P.O. Box 487, Robbinsville, NJ 08691 609-259-2776 609-259-3047-Fax

NJSIAA PARENT/GUARDIAN CONCUSSION POLICY ACKNOWLEDGMENT FORM

In order to help protect the student athletes of New Jersey, the NJSIAA has mandated that all athletes, parents/guardians and coaches follow the NJSIAA Concussion Policy.

A concussion is a brain injury and all brain injuries are serious. They may be caused by a bump, blow, or jolt to the head, or by a blow to another part of the body with the force transmitted to the head. They can range from mild to severe and can disrupt the way the brain normally works. Even though most concussions are mild, **all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly**. In other words, even a "ding" or a bump on the head can be serious. You can't see a concussion and most sports concussions occur without loss of consciousness. Signs and symptoms of concussion may show up right after the injury or can take hours or days to fully appear. If your child/player reports any symptoms of concussion, or if you notice the symptoms or signs of concussion yourself, seek medical attention right away.

Symptoms may include one or more of the following:
1. Headache.
2. Nausea/vomiting.
3. Balance problems or dizziness.
4. Double vision or changes in vision.
5. Sensitivity to light or sound/noise.
6. Feeling of sluggishness or fogginess.
7. Difficulty with concentration, short-term memory, and/or confusion.
8. Irritability or agitation.
9. Depression or anxiety.
10. Sleep disturbance.

Signs observed by teammates, parents and coaches include:
1. Appears dazed, stunned, or disoriented.
2. Forgets plays or demonstrates short-term memory difficulties (e.g. is unsure of the game, score, or opponent)
3. Exhibits difficulties with balance or coordination.
4. Answers questions slowly or inaccurately.
5. Loses consciousness.
6. Demonstrates behavior or personality changes.
7. Is unable to recall events prior to or after the hit.

What can happen if my child/player keeps on playing with a concussion or returns too soon?

Athletes with the signs and symptoms of concussion should be removed from play immediately. Continuing to play with the signs and symptoms of a concussion leaves the young athlete especially vulnerable to greater injury. There is an increased risk of significant damage from a concussion for a period of time after that concussion occurs, particularly if the athlete suffers another concussion before completely recovering from the first one. This can lead to prolonged recovery, or even to severe brain swelling (second impact syndrome) with devastating and even fatal consequences. It is well known that adolescent or teenage athletes will often under report symptoms of injuries. And concussions are no different. As a result, education of administrators, coaches, parents and students is the key for student-athlete's safety.

If you think your child/player has suffered a concussion

Any athlete even suspected of suffering a concussion should be removed from the game or practice immediately. No athlete may return to activity after an apparent head injury or concussion, regardless of how mild it seems or how quickly symptoms clear. Close observation of the athlete should continue for several hours.

An athlete who is suspected of sustaining a concussion or head injury in a practice or game shall be removed from competition at that time and may not return to play until the athlete is evaluated by a medical doctor or doctor of Osteopathy, trained in the evaluation and management of concussion and received written clearance to return to play from that health care provider.

You should also inform you child's Coach, Athletic Trainer (ATC), and/or Athletic Director, if you think that your child/player may have a concussion. And when it doubt, the athlete sits out.

For current and up-to-date information on concussions you can go to:

http://www.cdc.gov/ConcussionInYouthSports/

www.nfhslearn.com

Signature of Student-Athlete	Print Student-Athlete's Name	Date

Signature of Parent/Guardian	Print Parent/Guardian's Name	Date

Please keep this form on file at the school. Do not return to the NJSIAA. Thank you.

Website Resources

- Sudden Death in Athletes
  http://tinyurl.com/m2gjmvq
- Hypertrophic Cardiomyopathy Association
  www.4hcm.org
- American Heart Association www.heart.org

Collaborating Agencies:

American Academy of Pediatrics
New Jersey Chapter
3836 Quakerbridge Road, Suite 108
Hamilton, NJ 08619
(p) 609-842-0014
(f) 609-842-0015
www.aapnj.org

American Heart Association
1 Union Street, Suite 301
Robbinsville, NJ, 08691
(p) 609-208-0020
www.heart.org

New Jersey Department of Education
PO Box 500
Trenton, NJ 08625-0500
(p) 609-292-5935
www.state.nj.us/education/

New Jersey Department of Health
P. O. Box 360
Trenton, NJ 08625-0360
(p) 609-292-7837
www.state.nj.us/health

Lead Author: American Academy of Pediatrics, New Jersey Chapter

Written by: Initial draft by Sushma Raman Hebbar, MD & Stephen G. Rice, MD PhD

Additional Reviewers: NJ Department of Education, NJ Department of Health and Senior Services, American Heart Association/New Jersey Chapter, NJ Academy of Family Practice, Pediatric Cardiologists, New Jersey State School Nurses

Revised 2014: Nancy Curry, EdM; Christene DeWitt-Parker, MSN, CSN, RN; Lakota Kruse, MD, MPH; Susan Martz, EdM; Stephen G. Rice, MD; Jeffrey Rosenberg, MD, Louis Teichholz, MD; Perry Weinstock, MD

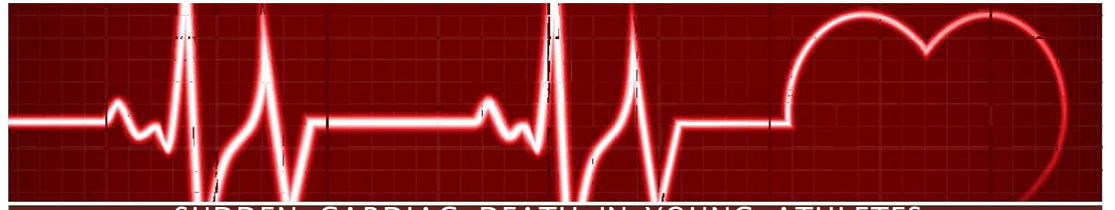
SUDDEN CARDIAC DEATH IN YOUNG ATHLETES

The Basic Facts on Sudden Cardiac Death in Young Athletes

STATE OF NEW JERSEY
DEPARTMENT OF EDUCATION

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

American Heart Association
Learn and Live



SUDDEN CARDIAC DEATH IN YOUNG ATHLETES

Sudden death in young athletes between the ages of 10 and 19 is very rare. What, if anything, can be done to prevent this kind of tragedy?

What is sudden cardiac death in the young athlete?

Sudden cardiac death is the result of an unexpected failure of proper heart function, usually (about 60% of the time) during or immediately after exercise without trauma. Since the heart stops pumping adequately, the athlete quickly collapses, loses consciousness, and ultimately dies unless normal heart rhythm is restored using an automated external defibrillator (AED).

How common is sudden death in young athletes?

Sudden cardiac death in young athletes is very rare. About 100 such deaths are reported in the United States per year. The chance of sudden death occurring to any individual high school athlete is about one in 200,000 per year.

Sudden cardiac death is more common: in males than in females; in football and basketball than in other sports; and in African-Americans than in other races and ethnic groups.

What are the most common causes?

Research suggests that the main cause is a loss of proper heart rhythm, causing the heart to quiver instead of pumping blood to the brain and body. This is called ventricular fibrillation (ven- TRICK-you-lar fib-roo-LAY-shun). The problem is usually caused by one of several cardiovascular abnormalities and electrical diseases of the heart that go unnoticed in healthy-appearing athletes.

The most common cause of sudden death in an athlete is hypertrophic cardiomyopathy (hi-per-TRO-fic CAR- dee-oh-my-OP-a-thee) also called HCM. HCM is a disease of the heart, with abnormal thickening of the heart muscle, which can cause serious heart rhythm problems and blockages to blood flow. This genetic disease runs in families and usually develops gradually over many years.

The second most likely cause is congenital (con-JEN-it-al) (i.e., present from birth) abnormalities of the coronary arteries. This means that these blood vessels are connected to the main blood vessel of the heart in an abnormal way. This differs from blockages that may occur when people get older (commonly called "coronary artery disease," which may lead to a heart attack).

SUDDEN CARDIAC DEATH IN YOUNG ATHLETES

Other diseases of the heart that can lead to sudden death in young people include:

- Myocarditis (my-oh-car-DIE-tis), an acute inflammation of the heart muscle (usually due to a virus).
- Dilated cardiomyopathy, an enlargement of the heart for unknown reasons.
- Long QT syndrome and other electrical abnormalities of the heart which cause abnormal fast heart rhythms that can also run in families.
- Marfan syndrome, an inherited disorder that affects heart valves, walls of major arteries, eyes and the skeleton. It is generally seen in unusually tall athletes, especially if being tall is not common in other family members.

Are there warning signs to watch for?

In more than a third of these sudden cardiac deaths, there were warning signs that were not reported or taken seriously. Warning signs are:

- Fainting, a seizure or convulsions during physical activity;
- Fainting or a seizure from emotional excitement, emotional distress or being startled;
- Dizziness or lightheadedness, especially during exertion;
- Chest pains, at rest or during exertion;
- Palpitations - awareness of the heart beating unusually (skipping, irregular or extra beats) during athletics or during cool down periods after athletic participation;
- Fatigue or tiring more quickly than peers; or
- Being unable to keep up with friends due to shortness of breath (labored breathing).

What are the current recommendations for screening young athletes?

New Jersey requires all school athletes to be examined by their primary care physician ("medical home") or school physician at least once per year. The New Jersey Department of Education requires use of the specific Preparticipation Physical Examination Form (PPE).

This process begins with the parents and student-athletes answering questions about symptoms during exercise (such as chest pain, dizziness, fainting, palpitations or shortness of breath); and questions about family health history.

The primary healthcare provider needs to know if any family member died suddenly during physical activity or during a seizure. They also need to know if anyone in the family under the age of 50 had an unexplained sudden death such as drowning or car accidents. This information must be provided annually for each exam because it is so essential to identify those at risk for sudden cardiac death.

The required physical exam includes measurement of blood pressure and a careful listening examination of the heart, especially for murmurs and rhythm abnormalities. If there are no warning signs reported on the health history and no abnormalities discovered on exam, no further evaluation or testing is recommended.

Are there options privately available to screen for cardiac conditions?

Technology-based screening programs including a 12-lead electrocardiogram (ECG) and echocardiogram (ECHO) are noninvasive and painless options parents may consider in addition to the required PPE. However, these procedures may be expensive and are not currently advised by the American Academy of Pediatrics and the American College of Cardiology unless the PPE reveals an indication for these tests. In addition to the expense, other limitations of technology-based tests include the possibility of "false positives" which leads to unnecessary stress for the student and parent or guardian as well as unnecessary restriction from athletic participation.

The United States Department of Health and Human Services offers risk assessment options under the Surgeon General's Family History Initiative available at http://www.hhs.gov/familyhistory/index.html.

When should a student athlete see a heart specialist?

If the primary healthcare provider or school physician has concerns, a referral to a child heart specialist, a pediatric cardiologist, is recommended. This specialist will perform a more thorough evaluation, including an electrocardiogram (ECG), which is a graph of the electrical activity of the heart. An echocardiogram, which is an ultrasound test to allow for direct visualization of the heart structure, will likely also be done. The specialist may also order a treadmill exercise test and a monitor to enable a longer recording of the heart rhythm. None of the testing is invasive or uncomfortable.

Can sudden cardiac death be prevented just through proper screening?

A proper evaluation should find most, but not all, conditionsthat wouldcause sudden death in the athlete. This is because some diseases are difficult to uncover and may only develop later in life. Others can develop following a normal screening evaluation, such as an infection of the heart muscle from a virus.

This is why screening evaluations and a review of the family health history need to be performed on a yearly basis by the athlete's primary healthcare provider. With proper screening and evaluation, most cases can be identified and prevented.

Why have an AED on site during sporting events?

The only effective treatment for ventricular fibrillation is immediate use of an automated external defibrillator (AED). An AED can restorethe heart back into a normal rhythm. An AED is also life-saving for ventricular fibrillation caused by a blow to the chest over the heart (commotio cordis).

N.J.S.A. 18A:40-41a through c, known as "Janet's Law," requires that at any school-sponsored athletic event or team practice in New Jersey public and nonpublic schools including any of grades K through 12, the following must be available:

- An AED in an unlocked location on school property within a reasonable proximity to the athletic field or gymnasium; and
- A team coach, licensed athletic trainer, or other designated staff member if there is no coach or licensed athletic trainer present, certified in cardiopulmonary resuscitation (CPR) and the use of the AED; or
- A State-certified emergency services provider or other certified first responder.

The American Academy of Pediatrics recommends the AED should be placed in central location that is accessible and ideally no more than a 1 to 1 1/2 minute walk from any location and that a call is made to activate 911 emergency system while the AED is being retrieved.

State of New Jersey
DEPARTMENT OF EDUCATION

Sudden Cardiac Death Pamphlet

Sign-Off Sheet

Name of School District: _____

Name of Local School: _____

I/We acknowledge that we received and reviewed the Sudden Cardiac Death in Young Athletes pamphlet.

Student Signature: _____

Parent or Guardian
Signature: _____

Date: _____

New Jersey Department of Education 2014: pursuant to the Scholastic Student-Athlete Safety Act, P.L. 2013, c.71

THE CRAIG SCHOOL
LOWER SCHOOL • MIDDLE SCHOOL
15 Tower Hill Road • Mountain Lakes, NJ 07046 • 973-334-1234 • www.craigschool.org

2023-2024
IN SCHOOL MEDICATION FORM

ALL MEDICATION (prescription and OTC, including Tylenol and Advil) must be accompanied by written permission from BOTH the PARENT and PHYSICIAN.

- Prescription medication must be delivered to the nurse by the parent in its original container, labeled with the student's name, medication, dosage, and physician's name.
- OTC medication must be delivered to school by the parent in the original sealed container and labeled with the student's name.
- Written permission from the student's physician and parent/guardian is required, including the student's name, the purpose of the medication, the time (or circumstances) at which the medication should be administered, and the length of time for which the medication is prescribed.

Only those medications which are medically necessary during school hours for a student's well being should be sent to school.

NOTE: THE FIRST DOSE OF ANY MEDICATION MAY NOT BE GIVEN AT SCHOOL

NAME OF STUDENT _____ DOB _____

NAME OF MEDICATION _____

DOSAGE _____

TIME TO BE GIVEN _____

REASON FOR MEDICATION _____

MEDICATION TO BE GIVEN FROM _____ TO _____
DATE DATE

HOW IT IS TAKEN _____
Example: By Mouth, Inhaler, with Food, Crushed, etc.

ADDITIONAL COMMENTS _____

_____ _____
PARENT SIGNATURE & DATE **PHYSICIAN SIGNATURE & DATE**

_____ _____
TELEPHONE NUMBER **TELEPHONE NUMBER**

ADDITIONAL MEDICATIONS

NAME OF STUDENT_____ **DOB**_____

NAME OF MEDICATION_____

DOSAGE_____

TIME TO BE GIVEN_____

REASON FOR MEDICATION_____

MEDICATION TO BE GIVEN FROM _____ **TO**_____
DATE **DATE**

HOW IT IS TAKEN_____
EXAMPLE: BY MOUTH, INHALER, WITH FOOD, CRUSHED, ETC.

ADDITIONAL COMMENTS_____

NAME OF STUDENT_____ **DOB**_____

NAME OF MEDICATION_____

DOSAGE_____

TIME TO BE GIVEN_____

REASON FOR MEDICATION_____

MEDICATION TO BE GIVEN FROM _____ **TO**_____
DATE **DATE**

HOW IT IS TAKEN_____
EXAMPLE: BY MOUTH, INHALER, WITH FOOD, CRUSHED, ETC.

ADDITIONAL COMMENTS_____

****

_____ _____
PARENT SIGNATURE / DATE **PHYSICIAN SIGNATURE / DATE**

_____ _____
TELEPHONE NUMBER **TELEPHONE NUMBER**

FOOD ALLERGY & ANAPHYLAXIS FORM

Date: September 2023

To: Parent/Guardians

Re.: 2023-2024 Food Allergy & Anaphylaxis Emergency Care Plan

Please review and sign the FARE (Food Allergy & Anaphylaxis Emergency Care Plan). Complete the entire form, obtain the required signatures, and return to The Craig School.

The FARE form addresses:

- Severe Symptoms
- Mild Symptoms
- Medications/Doses
- Directions - EpiPen Auto-Injector
- Directions - Adrenaclick
- Directions - AUVI-Q

In addition, please sign and return this memo along with the completed FARE form which requires Parent and Physician signatures.

As per the parent/guardian of the student listed below, I understand that if the procedures as specified in N.J.S.A. 18A:40-12.6 are followed, the district or nonpublic school shall have no liability as a result of any injury arising from the administration of the epinephrine via a pre-filled auto-injector mechanism to the pupil and that the parents or guardians shall indemnify and hold harmless the district, nonpublic school, and its employees or agents against any claims arising out of the administration of the epinephrine via a pre-filled auto-injector mechanism to the pupil.

Students Name: _____ School: **The Craig School**

Physician Signature: _____ Phone: _____
Date

Parent/Guardian Signature: _____ Phone: _____
Date

Thank you

Rev: 9/22/16

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergic to: _____

Weight: _____ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ **No**

PLACE PICTURE HERE

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

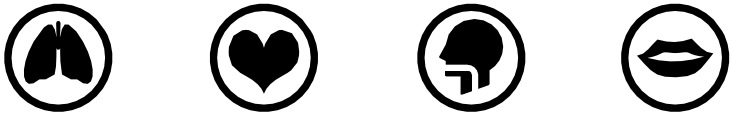
THEREFORE:

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

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

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS



LUNG
Shortness of breath, wheezing, repetitive cough

HEART
Pale or bluish skin, faintness, weak pulse, dizziness

THROAT
Tight or hoarse throat, trouble breathing or swallowing

MOUTH
Significant swelling of the tongue or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

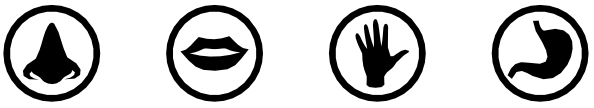
OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS



NOSE
Itchy or runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM A **SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

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

_____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

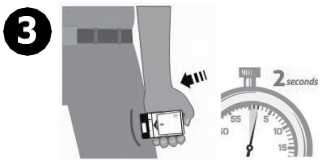
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

FARE
Food Allergy Research & Education

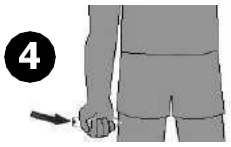
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

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



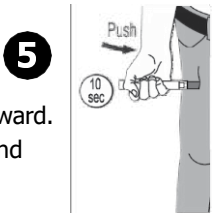
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

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



HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

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



HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.

HOW TO USE SYMJEPI™ (EPINEPHRINE INJECTION, USP)

1. When ready to inject, pull off cap to expose needle. Do not put finger on top of the device.
2. Hold SYMJEPI by finger grips only and slowly insert the needle into the thigh. SYMJEPI can be injected through clothing if necessary.
3. After needle is in thigh, push the plunger all the way down until it clicks and hold for 2 seconds.
4. Remove the syringe and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.
5. Once the injection has been administered, using one hand with fingers behind the needle slide safety guard over needle.

ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

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

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

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

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

Asthma Treatment Plan – Student

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

Sponsored by AMERICAN LUNG ASSOCIATION IN NEW JERSEY

PACNJ Pediatric/Adult Asthma Coalition

NJ Health New Jersey Department of Health

(Please Print)

Name	Date of Birth	Effective Date
Doctor Phone	Parent/Guardian (if applicable) Phone	Emergency Contact 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
Aerospan™	1, 2 puffs twice a day
Alvesco® 80, 160	1, 2 puffs twice a day
☐ Dulera® 100, 200	2 puffs twice a day
☐ Flovent® 44, 110, 220	2 puffs twice a day
☐ Qvar® 40, 80	1, 2 puffs twice a day
☐ Symbicort® 80, 160	1, 2 puffs twice a day
Advair Diskus® 100, 250, 500	1 inhalation twice a day
Asmanex® Twisthaler® 110, 220	1, 2 inhalations once or twice a day
☐ Flovent® Diskus® 50 100 250	1 inhalation twice a day
☐ Pulmicort Flexhaler® 90, 180	1, 2 inhalations once or twice a day
☐ Pulmicort Respules® (Budesonide) 0.25, 0.5, 1.0	1 unit nebulized once or twice a day
☐ Singulair® (Montelukast) 4, 5, 10 mg	1 tablet daily
☐ Other	
☐ None	

Remember to rinse your mouth after taking inhaled medicine.

If exercise triggers your asthma, take _____ ____puff(s) ____minutes before exercise.

CAUTION (Yellow Zone)

You have *any* of these:

- Cough
- Mild wheeze
- Tight chest
- Coughing at night
- Other:_____

If quick-relief medicine does not help within 15-20 minutes or has been used more than 2 times and symptoms persist, call your doctor or go to the emergency room.

And/or Peak flow from_____to_____

Continue daily control medicine(s) and ADD quick-relief medicine(s).

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

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

EMERGENCY (Red Zone)

Your asthma is getting worse fast:

- Quick-relief medicine did not help within 15-20 minutes
- Breathing is hard or fast
- Nose opens wide • Ribs show
- Trouble walking and talking
- Lips blue • Fingernails blue
- Other:_____

And/or Peak flow below _____

Take these medicines NOW and CALL 911.

Asthma can be a life-threatening illness. Do not wait!

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	4 puffs every 20 minutes
☐ Xopenex®	4 puffs every 20 minutes
Albuterol 1.25, 2.5 mg	1 unit nebulized every 20 minutes
☐ Duoneb®	1 unit nebulized every 20 minutes
☐ Xopenex® (Levalbuterol) 0.31, 0.63, 1.25 mg	1 unit nebulized every 20 minutes
☐ Combivent Respimat®	1 inhalation 4 times a day
☐ Other	

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.

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 5U58EH000401-5. Its contents 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 the document has been funded wholly or in part by the United States Environmental Protection Agency under Agreement X4982996I0-2 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.

REVISED MAY 2017

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_____

Physician's Orders

PARENT/GUARDIAN SIGNATURE_____

PHYSICIAN STAMP

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

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:**
  - v **Write in asthma medications not listed on the form**
  - v **Write in additional medications that will control your asthma**
  - v **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 _____

PACNJ Pediatric/Adult Asthma Coalition

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 5U59EH000491-5. 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 XA96296601-2 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