

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.

To be completed once every 365 days and returned to the Nurse's Office
Email: nurse@rutgersprep.org Fax: 732-745-2685

■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, non-binary, or another gender): _____

Have you had COVID-19? (check one): ☐ Y ☐ N

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 surgical procedures. _____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional). _____

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects). _____

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
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 subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if 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?			
HEART 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.			

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)		Yes	No	
9. Do you get light-headed or feel shorter of breath than your friends during exercise?				
10. Have you ever had a seizure?				
HEART 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?				

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■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

PHYSICIAN REMINDERS

- 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?
- Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height: _____	Weight: _____	
BP: _____ / _____ (_____ / _____)	Pulse: _____	Vision: R 20/ _____ L 20/ _____ Corrected: ☐ Y ☐ N
COVID-19 VACCINE		
Previously received COVID-19 vaccine: ☐ Y ☐ N		
Administered COVID-19 vaccine at this visit: ☐ Y ☐ N If yes: ☐ First dose ☐ Second dose ☐ Third dose ☐ Booster date(s) _____		
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat - Pupils equal - Hearing		
Lymph nodes		
Heart ^a Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional Double-leg squat test, single-leg squat test, and box drop or step drop test		

^a Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

Preparticipation Physical Evaluation Medical Eligibility Form

Student Athlete's Name _____ Date of Birth _____

Date of Exam _____

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

Recommendations: _____

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

Signature of physician, APN, PA _____

Office stamp (optional)

Address: _____

Name of healthcare professional (print) _____

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

Signature of healthcare provider _____

Shared Health Information

Allergies _____

Medications:

Other information: _____

Emergency Contacts: _____

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

Asthma Treatment Plan – Student

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

The Pediatric/Adult
Asthma Coalition
of New Jersey
"Your Pathway to Asthma Control"
PACNJ approved Plan available at
www.pacnj.org

Sponsored by
AMERICAN
LUNG
ASSOCIATION
IN NEW JERSEY

NJHealth
New Jersey Department of Health



(Please Print)

Name	Date of Birth	Effective Date
Doctor	Parent/Guardian (if applicable)	Emergency Contact
Phone	Phone	Phone

HEALTHY (Green Zone) IIII➡



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.

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:
 - _____
 - _____
 - _____

CAUTION (Yellow Zone) IIII➡



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) IIII➡



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	

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

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.

REVISED AUGUST 2014

Permission to reproduce blank form - www.pacnj.org

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 & phone number
- Child's date of birth
- An Emergency Contact person's name & phone number

2. Your Health Care Provider will complete the following areas:

- The effective date of this plan
- The medicine information for the Healthy, Caution and Emergency sections
- Your Health Care Provider will check the box next to the medication and check how much and how often to take it
- Your Health Care Provider may check **"OTHER"** and:
 - ❖ Write in asthma medications not listed on the form
 - ❖ Write in additional medications that will control your asthma
 - ❖ Write in generic medications in place of the name brand on the form
- Together you and your Health Care Provider will decide what asthma treatment is best for your child to follow

3. Parents/Guardians & Health Care Providers together will discuss and then complete the following areas:

- Child's peak flow range in the Healthy, Caution and Emergency sections on the left side of the form
- Child's asthma triggers on the right side of the form
- Permission to Self-administer Medication section at the bottom of the form: Discuss your child's ability to self-administer the inhaled medications, check the appropriate box, and then both you and your Health Care Provider must sign and date the form

4. Parents/Guardians: After completing the form with your Health Care Provider:

- Make copies of the Asthma Treatment Plan and give the signed original to your child's school nurse or child care provider
- Keep a copy easily available at home to help manage your child's asthma
- Give copies of the Asthma Treatment Plan to everyone who provides care for your child, for example: babysitters, before/after school program staff, coaches, scout leaders

PARENT AUTHORIZATION

I hereby give permission for my child to receive medication at school as prescribed in the Asthma Treatment Plan. Medication must be provided in its original prescription container properly labeled by a pharmacist or physician. I also give permission for the release and exchange of information between the school nurse and my child's health care provider concerning my child's health and medications. In addition, I understand that this information will be shared with school staff on a need to know basis.

Parent/Guardian Signature

Phone

Date

FILL OUT THE SECTION BELOW ONLY IF YOUR HEALTH CARE PROVIDER CHECKED PERMISSION FOR YOUR CHILD TO SELF-ADMINISTER ASTHMA MEDICATION ON THE FRONT OF THIS FORM.

RECOMMENDATIONS ARE EFFECTIVE FOR ONE (1) SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY

- ☐ I do request that my child be **ALLOWED** to carry the following medication _____ for self-administration in school pursuant to N.J.A.C.:6A:16-2.3. I give permission for my child to self-administer medication, as prescribed in this Asthma Treatment Plan for the current school year as I consider him/her to be responsible and capable of transporting, storing and self-administration of the medication. Medication must be kept in its original prescription container. I understand that the school district, agents and its employees shall incur no liability as a result of any condition or injury arising from the self-administration by the student of the medication prescribed on this form. I indemnify and hold harmless the School District, its agents and employees against any claims arising out of self-administration or lack of administration of this medication by the student.
- ☐ I **DO NOT** request that my child self-administer his/her asthma medication.

Parent/Guardian Signature

Phone

Date

**FARE**

Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ Grade: _____ D.O.B.: _____

Diagnosis/Allergic to _____

Weight _____ lbs Asthma: ☐ No ☐ Yes (higher risk for a severe reaction)**PLACE
PICTURE
HERE****NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE****Extremely reactive to the following insects/foods:** _____
THEREFORE:

- ☐ If checked, give epinephrine immediately for ANY symptoms if the allergen food was likely eaten / or stung
- ☐ If checked, give epinephrine immediately if the allergen was definitely eaten / or stung, even if no symptoms are noted

**FOR ANY OF THE FOLLOWING:
SEVERE SYMPTOMS****LUNG**Short of breath,
wheezing,
repetitive cough**HEART**Pale, blue,
faint, weak
pulse, dizzy**THROAT**Tight, hoarse,
trouble
breathing/
swallowing**MOUTH**Significant
swelling of the
tongue and/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 them the child is having anaphylaxis and may need epinephrine when they 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 them to ER even if symptoms resolve. Person should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS**NOSE**Itchy/runny
nose,
sneezing**MOUTH**

Itchy mouth

**SKIN**A few hives,
mild itch**GUT**Mild nausea/
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 auto-injectable dose:

☐ 0.15 mg IM ☐ 0.3 mg IM

Diphenhydramine (i.e. Benadryl) by mouth

☐ 12.5 mg ☐ 25 mg ☐ 50mg ☐ other _____ mgOther (i.e., inhaler-bronchodilator if wheezing):

- ☐ This student is not approved to self-medicate.
- ☐ This student is capable and has been instructed in the proper method of self administering the initial dose of the auto-injectable epinephrine device named above in accordance with NJ State Law. The student shall carry the medication in the original labeled container noted above at all times in school and at school sponsored activities.

Medical Provider's stamp with address

Physician/DO/APN/PA Signature _____

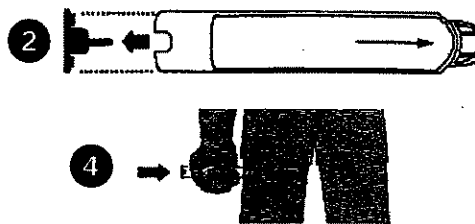
Date _____

Trained delegates in the administration of initial dose of auto-injectable epinephrine

Name: _____ Location: _____
 Name: _____ Location: _____
 Name: _____ Location: _____

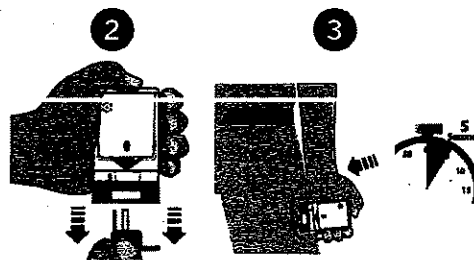
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



ADRENALICK®/ADRENALICK® GENERIC DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.



Treat someone before calling Emergency Contacts. The first signs of a reaction can be mild, but symptoms can get worse quickly.

EMERGENCY CONTACTS— CALL 9-1-1

Medical Provider: _____ Phone: _____
 Parent/Guardian: _____ Phone: _____
 Parent/Guardian: _____ Phone: _____

OTHER EMERGENCY CONTACTS

Name/Relationship: _____ Phone: _____
 Name/Relationship: _____ Phone: _____

I give permission for my child to receive medication at school as prescribed in this Food Allergy & Anaphylaxis Emergency Care Plan. Medication shall be provided in its original prescription container and properly labeled by the pharmacist or medical provider. I 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. I understand this information will be shared with school staff on a need-to-know basis. This plan is in effect for the current school year and summer programs.

It is the parents' responsibility to inform the School Nurse when their child will be staying at an after-school sponsored activity. The School Nurse may train volunteers to act as a delegate to administer epinephrine via a pre-filled auto-injector to my child for anaphylaxis or possible anaphylaxis when the School Nurse is not physically present at the scene. I give consent for the trained delegate(s) to administer the initial dose of the epinephrine as indicated.

I acknowledge that Rutgers Preparatory School, Board of Trustees, employees and/or its agents shall incur no liability as a result of any injury arising from the administration (or self administration, if permitted) of medication to my child. I shall indemnify and hold harmless Rutgers Preparatory School, Board of Trustees, employees, and/or its agents against any claims arising out of the administration (or self administration, if permitted) of this medication to my child.

☐ I request and give permission for my child to be **ALLOWED** to carry the above mentioned medication for self-administration as prescribed in this plan. I consider him/her responsible and capable of self-administering the medication(s) above.

☐ I **DO NOT** give permission for my child to self administer his/her above mentioned medication(s).

Printed Parent Name: _____ Parent Signature: _____ Date: _____

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Rutgers Preparatory School

Medication Form

Office of School Nurse

Maureen Olsen, RN

Maria Bowers, RN

Phone: (732) 545-5600 ext. 224

Fax: (732) 745-2685

E-mail: nurse@rutgersprep.org

Dear Parent,

Only the School Nurse (or the student's parent) shall administer medication (prescription or over-the-counter) if a student is required to receive medication while attending school or school functions. All medications require written orders from a licensed medical provider and signature from the parent. All medication(s) shall be delivered to the School Nurse by the parent or other designated adult in the original labeled container with the student's name, medication name, medication route, dosage, time and/or other directions, date, and medical provider's name. For prescription medications, please ask the pharmacist to prepare two labeled containers. Herbs and dietary supplements are not considered medications and will not be administered. The parent is responsible to pick up any remaining medication at the end of treatment regime or at the end of the school year or it shall be destroyed seven days after the end of treatment. The only exception for which a student may be permitted to carry and self-administer his/her own medication shall be for a potentially life-threatening illness.

To Be Completed by Licensed Medical Provider:

Student: _____ D.O.B.: _____ Grade: _____

Diagnosis: _____

Name of Medication, Dosage, and Route: _____

Frequency and Indication To Be Administered: _____

Length of Time To Be Given: _____

Possible Side Effects: _____

Physician/DO/APN/PA Signature_____
Date

Medical Provider's Stamp with Address

.....

I hereby request the School Nurse to administer the above medication to my child as prescribed by the medical provider. I give permission for the release and exchange of information between the school nurse and my child's health care providers 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. This authorization is effective for the current school year and summer programs.

I acknowledge that Rutgers Preparatory School, Board of Trustees, employees, and/or its agents shall incur no liability as a result of any injury arising from the administration of medication to my child. I shall indemnify and hold harmless Rutgers Preparatory School, Board of Trustees, employees, and/or its agents against any claims arising out of the administration of medication to my child.

Print Name of Parent_____
Signature of Parent_____
Date