Rutgers Preparatory School 1345 Easton Avenue Somerset, NJ 08873
Phone (732) 545-5600 ext. 224 Fax (732) 745-2685

GRADES PK-5 ANNUAL PHYSICAL EXAMINATION FORM

PHYSICAL EXAMINATIONS MUST BE COMPLETED ONCE EVERY 365 DAYS AND RETURNED TO THE NURSES' OFFICE
e-mail: nurse@rutgersprep.org, or fax: (732) 745-2685

Name:_____Gender: M F Grade: _____Date of Birth:_____/_____/_____

Medical Care Provider's Name: _____ Phone: _____ Fax:_____

Part I-Health History Questionnaire-To Be Completed By Parent *Before* Physical Evaluation

Does your child currently, or in the past, have any of the following conditions? Please complete the following checklist giving details and year when illness/injury occurred.

	YES	NO	DATE
Allergies: Medications, Food or Seasonal (list below)			
Allergy to Bee / Insect Sting (*Severe* reaction requiring Emergency Epinephrine)			
ADD / ADHD			
Anemia / Sickle Cell			
Arthritis			
Asthma / Reactive Airway Disease			
Back / Neck Injury			
Blood / Clotting Disorder			
Cancer / Leukemia			
Chickenpox-disease date			
Dental Problems			
Depression			
Diabetes			
Head Injury / Concussion			
Headaches / Migraines			

	YES	NO	DATE
Hearing Deficit / Ear Tubes			
Heart Condition / Murmur / Rheumatic Fever / Blood Pressure			
Hepatitis			
Hernia			
Kidney / Bladder Disorder			
Lung Disease / TB / Pertussis			
Lyme Disease			
Mononucleosis			
Orthopedic Problems / Fractures			
Physical Disability/Activity Restrictions			
Seizure Disorder			
Surgery			
Speech Problems / Therapy			
Vision Impairment/Glasses/Contacts			
Other: (explain below)			

Explain other illness/health conditions and all "yes" answers listed above including relevant dates: _____

_____

_____

Is your child under any medical care/treatment now? ___YES ____NO Specify: _____

_____

_____

Is your child taking any medication on a regular basis (prescription or over-the-counter)? ___YES ___NO

List medication(s), dosage, frequency, and reasons for usage _____

_____

_____

NJ State law requires written permission from a licensed medical provider and parent before **ANY medication is administered in school. Please obtain a medication form(s) from the School Nurse's Office if your child requires medication while in school. All medication is overseen through the School Nurse's Office.

I certify that the information provided herein is accurate to the best of my knowledge as of the date of my signature. I give consent for my child's health information to be shared on a "need-to-know" basis with faculty/staff and emergency care personnel who may be responsible for my child's care. I give consent for the School Nurse to exchange information with my child's health care provider regarding pertinent health issues. I agree to alert the School Nurse on any changes in medication and/or the health status of my child.

Printed Parent Name: _____

Parent Signature:_____Signature Date: _____

THE COMPLETED AND SIGNED HEALTH HISTORY MUST BE REVIEWED BY THE EXAMINING PROVIDER AT THE TIME OF THE MEDICAL EXAMINATION

Part II-Physical Evaluation-Completed by the examining licensed provider MD, DO, APN or PA

Name _____ Grade _____ Gender M F Date of Birth _____

******FINDINGS OF PHYSICAL EVALUATION******

Height: _____Weight: _____Blood Pressure: ____/____Pulse: _____bpm. Vision: R 20/____L 20/ ____Contacts: Y / N Glasses: Y / N

INDICATORS	NORMAL?	ABNORMAL FINDINGS/COMMENTS
General Appearance	YES	
Head/Neck	YES	
Eyes/Sclera/Pupils	YES	
Ears	YES	
Gross Hearing	YES	
Nose/Mouth/Throat/Dental	YES	
Lymph Glands	YES	
Cardiovascular	YES	
Heart Rate	YES	
Rhythm	YES	
Murmur	ABSENT	
If murmur present		Standing makes it: Louder Softer No Change
		Squatting makes it: Louder Softer No Change
		Valsalva makes it: Louder Softer No Change
Femoral Pulses	YES	
Lungs: Auscultation/Percussion	YES	
Chest Contour	YES	
Skin	YES	
Abdomen (liver, spleen, masses)	YES	
Assessment of Physical Maturation or Tanner	YES	
Testicular Exam (Males Only)	YES	
Neck/Back/Spine:	YES	
Range of Motion	YES	
Scoliosis	ABSENT	
Upper Extremities: (ROM, Strength, Stability)	YES	
Lower Extremities: (ROM, Strength, Stability)	YES	
Neurological: Balance & Coordination	YES	
Hernia	ABSENT	
Evidence of Marfan Syndrome	ABSENT	

Most recent immunizations and dates administered (new students please attach full immunization record): _____

Medications currently prescribed, with dose and frequency:

Medication Name	Dosage	Frequency

Recent Injuries/Operations/Additional Observations: _____

General Diagnosis/Medical Concerns: _____

General Recommendations: _____

Conditions requiring clearance before physical education participation include, but are not limited to: Anaphylaxis; Atlantoaxial instability; Bleeding disorder; Hypertension; Congenital heart disease: Dysrhythmia; Mitral valve prolapse; Heart murmur; Cerebral palsy; Diabetes; Eating disorders; Heat illness history; One-kidney athletes; Hepatomegaly, Splenomegaly; Malignancy; Seizure disorder; Marfan syndrome; History of repeated concussion; Organ transplant recipient; Cystic fibrosis; Sickle cell disease; and/or One-eyed athletes or athletes with vision greater than 20/40 in one eye.

I have examined the above child and reviewed his/her health history prepared by the parent. It is my opinion that he/she is medically cleared to participate in all child care/school activities, including physical education and competitive contact sports without restriction unless noted above.

License Type: MD/DO ❑ APN ❑ PA ❑

Licensed Medical Care Provider's Stamp:

Physician's/Provider's Name (Print) _____

Physician's/Provider's Signature_____

Today's Date: _____ Date of Examination: _____

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"
www.pacnj.org

Sponsored by AMERICAN LUNG ASSOCIATION.

NJ Health New Jersey Department of Health

(Please Print)

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

HEALTHY (Green Zone)

You have all of these:
- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work, exercise, and play

And/or Peak flow above _____

Take daily control medicine(s). Some inhalers may be more effective with a "spacer" – use if directed.

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
O Advair® HFA O 45, O 115, O 230	2 puffs twice a day
O Aerospan™	O 1, O 2 puffs twice a day
O Alvesco® O 80, O 160	O 1, O 2 puffs twice a day
O Dulera® O 100, O 200	2 puffs twice a day
O Flovent® O 44, O 110, O 220	2 puffs twice a day
O Qvar® O 40, O 80	O 1, O 2 puffs twice a day
O Symbicort® O 80, O 160	O 1, O 2 puffs twice a day
O Advair Diskus® O 100, O 250, O 500	1 inhalation twice a day
O Asmanex® Twisthaler® O 110, O 220	O 1, O 2 inhalations O once or O twice a day
O Flovent® Diskus® O 50 O 100 O 250	1 inhalation twice a day
O Pulmicort Flexhaler® O 90, O 180	O 1, O 2 inhalations O once or O twice a day
O Pulmicort Respules® (Budesonide) O 0.25, O 0.5, O 1.0	1 unit nebulized O once or O twice a day
O Singulair® (Montelukast) O 4, O 5, O 10 mg	1 tablet daily
O Other	
O 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
O Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	2 puffs every 4 hours as needed
O Xopenex®	2 puffs every 4 hours as needed
O Albuterol O 1.25, O 2.5 mg	1 unit nebulized every 4 hours as needed
O Duoneb®	1 unit nebulized every 4 hours as needed
O Xopenex® (Levalbuterol) O 0.31, O 0.63, O 1.25 mg	1 unit nebulized every 4 hours as needed
O Combivent Respimat®	1 inhalation 4 times a day
O Increase the dose of, or add:	
O 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
O Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	4 puffs every 20 minutes
O Xopenex®	4 puffs every 20 minutes
O Albuterol O 1.25, O 2.5 mg	1 unit nebulized every 20 minutes
O Duoneb®	1 unit nebulized every 20 minutes
O Xopenex® (Levalbuterol) O 0.31, O 0.63, O 1.25 mg	1 unit nebulized every 20 minutes
O Combivent Respimat®	1 inhalation 4 times a day
O Other	

Triggers

Check all items that trigger patient's asthma:

- ❑ Colds/flu
- ❑ Exercise
- ❑ Allergens
  - o Dust Mites, dust, stuffed animals, carpet
  - o Pollen - trees, grass, weeds
  - o Mold
  - o Pets - animal dander
  - o Pests - rodents, cockroaches
- ❑ Odors (Irritants)
  - o Cigarette smoke & second hand smoke
  - o Perfumes, cleaning products, scented products
  - o Smoke from burning wood, inside or outside
- ❑ Weather
  - o Sudden temperature change
  - o Extreme weather - hot and cold
  - o Ozone alert days
- ❑ Foods:
  - o _____
  - o _____
  - o _____
- ❑ Other:
  - o _____
  - o _____
  - o _____

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 5U88EH000431-5. 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 this document has been funded wholly or in part by the United States Environmental Protection Agency under Agreement XA96299601-2 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 AUGUST 2014

Permission to Self-administer Medication:

- O 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.
- O 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 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

O 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.

O I DO NOT request that my child self-administer his/her asthma medication.

Parent/Guardian Signature _____ Phone _____ Date _____

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

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

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FARE 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)**

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

PLACE PICTURE HERE

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___ mg

Other (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

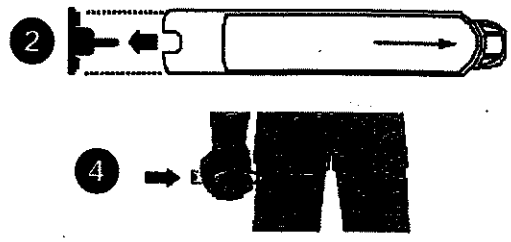
Name: _____ Location: _____

Name: _____ Location: _____

Name: _____ Location: _____

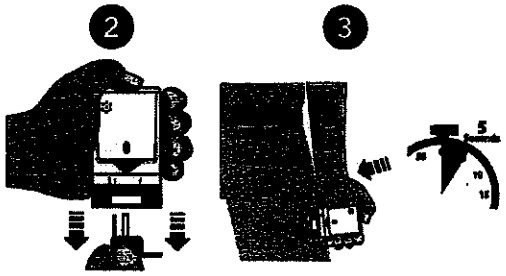
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

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.



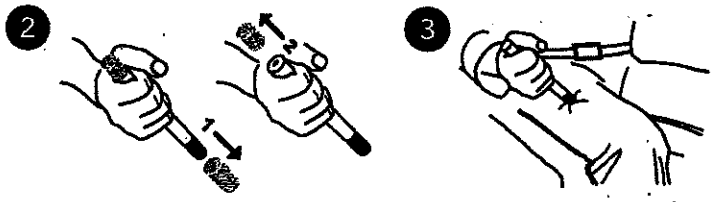
AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

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.



ADRENACLICK®/ADRENACLICK® 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		OTHER EMERGENCY CONTACTS	
Medical Provider: _____	Phone: _____	Name/Relationship: _____	Phone: _____
Parent/Guardian: _____	Phone: _____	Name/Relationship: _____	Phone: _____
Parent/Guardian: _____	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-administrating 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 hearby 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

8/21/2015