River Dell Regional School District

230 Woodland Avenue
River Edge, New Jersey 07661
www.riverdell.org

Office of the Superintendent

Dr. James J. Albro **201-599-7206**
SUPERINTENDENT OF SCHOOLS **Fax: 201-261-3809**

March, 2023

Dear 7th/8th Grade Parent/Guardian:

Welcome to the River Dell Regional School District! We look forward to your student joining RDMS and we hope their experience at River Dell will be a rewarding one.

Attached please find detailed instructions to successfully register your student:

- **REQUIRED REGISTRATION DOCUMENTS CHECKLIST AND INSTRUCTIONS**
- **REQUIRED HEALTH INFORMATION AND INSTRUCTIONS**

Please feel free to contact this office should you have any questions. Thank you for your assistance!

Sincerely yours,

Nancy Boettger

Nancy Boettger
District Registrar
201-599-7255

Enclosures
/nmb

River Dell Regional School District

Registration Checklist

1. **Provide ALL of the following *(each form must be completed in its entirety):***

___ Registration/Emergency Contact Form *(three pages),* **AND**

___ Affidavit of Residency Form (***MUST BE NOTARIZED),*** **AND**

___ Copy of Student's birth certificate **OR** passport, **AND**

___ Copy of Parent/Guardian's photo ID - valid driver's license **OR** passport, **AND**

___ Student Records Release Form (*must include all contact information*), **AND**

___ Home Language Survey Form, **AND**

___ Most recent report card/state test scores, **AND**

___ IMMUNIZATIONS *(obtain printout from physician's office)*, **AND**

___ State of New Jersey Preparticipation Physical Evaluation (*four pages),* **AND**

___ Additional health forms, if applicable, as outlined in Mrs. Puleo's letter.

2. **Provide a copy of ONE of the following:**
Must show residence within boroughs of Oradell or River Edge.

___ Lease - showing effective dates during the current school year and signatures, **OR**

___ A recorded deed **AND** current property tax bill/statement

3. **Provide a copy of ONE of the following with your current address:**

___ Current utility bill (*Service and Mailing address*), **OR**

___ Current telephone bill, **OR**

___ Current bank statement (with monetary information blocked)

/nmb

River Dell Middle School

230 Woodland Avenue, River Edge, NJ 07661

Francesca Puleo, RN, CSN
School Nurse
201-599-7280
Fax: 201-599-2202

REQUIRED HEALTH INFORMATION

March, 2023

Dear 7th/8th Grade Parents/Guardians,

I would like to take this opportunity to welcome you to River Dell Middle School. I hope that the school year brings forth successful performance and academic achievement.

All Incoming students are required to submit IMMUNIZATIONS and their PHYSICAL according to River Dell Board of Education Policy 5141.3 and the New Jersey Statutes and Administrative Code.

- ***Any physical dated 9/1/2022 or later will be accepted.*** The **originals must** be submitted with the Registration packet. *We cannot accept any faxes or copies*.
- Please have your physician complete the necessary forms, which are included in the registration link indicated in this packet.

The following forms are included in the link:

- **MANDATORY - State of New Jersey IMMUNIZATIONS and HEALTH HISTORY Form**
- **ONLY if applicable - Asthma Treatment Plan Form**
- **ONLY if applicable - Food Allergy & Anaphylaxis Emergency Care Plan Form**
- **ONLY if applicable - Administering Medication Permission Form**
- If other medical conditions exist, please contact Mrs. Puleo for further information.

- **IMPORTANT: All completed medical forms and immunizations must be ORIGINAL and MUST be received by Mrs. Puleo, RDMS School nurse, prior to the student's first day of school.** *They may be mailed or delivered with the Registration packet*:

River Dell Middle School
Attn: Nancy Boettger
230 Woodland Avenue
River Edge, NJ 07661

It is my belief that communication is very important and I welcome our interaction. Please feel free to contact me with any questions or concerns that may arise. I may be reached by telephone at 201-599-7280, or through e-mail at Francesca.Puleo@riverdell.org. Thank you for your assistance.

Sincerely yours,

Francesca Puleo

Francesca Puleo, RN, CSN
River Dell Middle School Nurse

River Dell Regional School District

230 Woodland Avenue, River Edge, NJ 07661

REGISTRATION / EMERGENCY CONTACT FORM - Page 1 of 3

TO BE COMPLETED BY OFFICE

Student ID #: _____ **School Year:** 2023-2024 **Registration Date:** _____ **Parent Portal:** _____
Family ID #: _____ **Grade:** _____ **Actual Start Date:** _____ **Community Pass:** _____
Class of: _____ **Counselor:** _____ **Transcript Request:** _____ **NJ SMART:** _____

STUDENT INFORMATION

First / Middle / Last:

Student's Legal Name from Birth Certificate: _____ Nickname: _____

Address: _____ Town: _____

Home Telephone Number: _____ Gender: ☐ Male ☐ Female

Date of Birth: _____

City/State of Birth: _____

Country of Birth: _____

Ethnicity (Must check ONE or ALL that apply): ☐ American Indian/Alaskan ☐ Asian ☐ Black ☐ Hawaiian Native/Pacific Islander ☐ Hispanic ☐ White

Sibling Information (name/age/school): _____

FAMILY INFORMATION

LEGAL GUARDIAN #1 : ☐ **Mother** ☐ **Father** ☐ **Other** _____ **Student's Legal Residence:** ☐ **YES** ☐ **NO**

First Name *(check one)*: Mr / Mrs / Ms _____ Last Name: _____

Mailing Address: **SAME AS STUDENT *(initial to confirm)*** _____ Employer Name: _____

Cell Phone #: _____ Employer Address: _____ City: _____

Home Phone #: _____ Work Phone #: _____

Email Address Required: _____ Occupation: _____

Military Connection: *(check one)* Not Connected / Active Duty / National Guard-Reserve

LEGAL GUARDIAN #2 : ☐ **Mother** ☐ **Father** ☐ **Other** _____ **Student's Legal Residence:** ☐ **YES** ☐ **NO**

First Name *(check one)*: Mr / Mrs / Ms _____ Last Name: _____

Full Address (if different): _____ City: _____ Employer Name: _____

Cell Phone #: _____ Employer Address: _____ City: _____

Home Phone #: _____ Work Phone #: _____

Email Address Required: _____ Occupation: _____

Military Connection: *(check one)* Not Connected / Active Duty / National Guard-Reserve

LEGAL GUARDIAN #3 : ***NON-CUSTODIAL PARENT or student resides at more than one address (if applicable)*** ☐ **Mother** ☐ **Father** ☐ **Other** _____

☐ **CONTACT ALLOWED** ☐ **RECEIVES ALL NOTIFICATIONS*** ☐ **NO CONTACT ALLOWED**

First Name *(check one)*: Mr / Mrs / Ms _____ Last Name: _____

Full Address: _____ City: _____ Employer Name: _____

*Cell Phone #: _____ Employer Address: _____ City: _____

Home Phone #: _____ Work Phone #: _____

*Email Address: _____ Occupation: _____

Military Connection: *(check one)* Not Connected / Active Duty / National Guard-Reserve

REGISTRATION / EMERGENCY CONTACTS - Page 2 of 3

List two neighbors or nearby relatives who will assume temporary care of your student if you cannot be reached.

Name: _____ Name: _____

Address: _____ Address: _____

City/State/Zip: _____ City/State/Zip: _____

Relationship: _____ Relationship: _____

Cell Phone #: _____ Cell Phone #: _____

Home Phone #: _____ Home Phone #: _____

PREVIOUS SCHOOL INFORMATION

Name of School: _____ Principal's Name: _____

Address: _____ School Telephone Number: _____

City/State/Zip: _____ Transfer Date: _____ Grade: _____

Please review and respond to all of the following:

1. Language(s) spoken at home: _____ Dialect *(if applicable)* : _____
2. Date student entered the United States: _____ *(if applicable)* Date student entered a U.S. School: _____

3. Does a *court-ordered* Child Custody Order exist?	☐	Yes	☐	No
4. Has student ever had a 504 Plan?	☐	Yes	☐	No
5. Has student ever been referred for a Special Education evaluation?	☐	Yes	☐	No
6. Has student ever been evaluated by a Special Education Child Study Team?	☐	Yes	☐	No
7. Has student ever been classified for Special Education/Related Services/Speech Services?	☐	Yes	☐	No
8. Has student ever had an Individualized Education Plan or an Individualized Service Plan?	☐	Yes	☐	No
9. Is there any reason to suspect that your student may have a learning/emotional/physical issue?	☐	Yes	☐	No
10. Is this student's home address a temporary living arrangement?	☐	Yes	☐	No
11. Is this a temporary living arrangement due to loss of housing or economic hardship?	☐	Yes	☐	No
12. Is this student in temporary or emergency foster care placement?	☐	Yes	☐	No
13. Is the student not living with a parent or legal guardian?	☐	Yes	☐	No

14. Where is the student currently living:

- ☐ With <u>more</u> than one family in a house or apartment.
- ☐ Temporary/emergency foster home.
- ☐ In a motel/hotel - Name of motel/hotel: _____
- ☐ Transitional Housing - Name of transitional housing: _____
- ☐ Group Home - Name of group home: _____
- ☐ Moving from place to place or a location not designed for sleeping accommodations, (example: car, park, or campsite).
- ☐ None of the above.

If you have additional information you think the district should be aware of, please indicate: _____

REGISTRATION / STUDENT MEDICAL INFORMATION - Page 3 of 3

First / Middle / Last:

Student's Legal Name from Birth Certificate: _____ RDMS Student ID #: _____

Nickname: _____

HEALTH INSURANCE

Does this student have health insurance, including NJ FamilyCare/Medicaid, Medicare, private or other?

☐ Yes - Full Name of Insurance Company: _____

☐ No - If student is not covered by health insurance, please complete the following for NJ FamilyCare:

NJ FAMILYCARE

- NJ FamilyCare provides free or low-cost health insurance for uninsured students and certain low-income parents.
- For more information, call 800-701-0710 or visit www.njfamilycare.org to apply online.
- If you would like to be contacted by the NJ FamilyCare Program about health insurance, please complete the following:

☐ Yes, you may release my name and address to the NJ FamilyCare Program to contact me about health insurance.

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

Signature _____ **Printed Name** _____ **Date** _____

MEDICAL HISTORY

Doctor's Name: _____ Doctor's Phone #: _____

Dentist's Name: _____ Dentist's Phone #: _____

Hospital *(check one)*: ☐ Englewood Health | ☐ Hackensack Hospital | ☐ Holy Name Med Ctr | ☐ Pascack Valley Med Ctr | ☐ Valley Hospital

Please list dates/types of medical/surgical care your student has received: _____

Allergies: (*Type & medications/dosages*) _____

Allergic Reaction: (*Date & medications/dosages*) _____

Restrictions: (*Type*) _____

Last Dental Exam: (*Date*) _____ Braces: _____

Last Eye Exam: (*Date*) _____ Contacts/Glasses: _____

Has student ever had an Individualized Healthcare Plan: (circle one) ☐ NO ☐ YES If Yes, when: _____

If you have additional information you think the district should be aware of, please indicate: _____

HOLD HARMLESS AGREEMENT (MUST BE SIGNED BY PARENT/GUARDIAN)

I, THE UNDERSIGNED, DO HEREBY AUTHORIZE OFFICIALS OF New Jersey Public Schools to contact directly the persons named on this form and do authorize the named physicans to render such treatment as may be deemed necessary in an emergency, for the health of said student.

In the event that physicans, other persons named on this form or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid student.

I will not hold the school district financially responsible for the emergency care and/or transportation of said student.

Signature of Parent(s)/Guardian(s) _____ **Printed Name** _____ **Date** _____

Revised 3/2023

River Dell Regional School District

230 Woodland Avenue, River Edge, NJ 07661

AFFIDAVIT OF RESIDENCY

Date: _____

I *(name)*_____, affirm that I am the *(check one)*: ____ Parent ____ Guardian ____ "Affidavit Host" of the student(s) listed below, and hereby certify that my student(s) and I are officially residing at the following address: _____ in the Borough of _____.

Name of Student(s)	Age	Grade	School Currently Attending	Date of Birth
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

I hereby submit the following documents, which establish that my student(s) and I are domiciled in the Borough of Oradell or River Edge (check all that apply):

PLEASE PROVIDE DOCUMENT(S) FROM EACH SECTION AS INDICATED:

(Please note that additional documentation may be required.)

1 - RESIDENCY:

_____ Original lease, effective during the current school year, **OR**

_____ Recorded deed showing ownership of a residence (within the Boroughs of Oradell or River Edge)

_____ **AND** a current property tax bill/statement

2 – ADDRESS VERIFICATION *(must include mailing address)*:

_____ Current bank statement (please block out all monetary information), **OR** _____Current utility statement

3 – PHOTO ID:

_____ Copy of a valid driver's license, **OR** _____ Copy of a valid passport

4 – If you are not the student's parent or legal guardian (*if applicable*):

_____ A current signed Affidavit form stating that the student(s) listed above resides with you and is financially dependent upon you even though you are not the student's parent or legal guardian. Attach to the Residency Form documentation of financial dependency, i.e., IRS return showing student(s) as dependent(s).

I further state that this form and the attached documents constitute true and accurate proof that the student(s) listed reside with me within the Boroughs of Oradell or River Edge and will continue to do so for the entire school year. If any student listed stops living with me, or if I move my residence out of Oradell or River Edge within the school year, I will promptly notify the River Dell Board of Education in writing.

If it is determined that the aforementioned stated address is not my valid residence, I acknowledge that I will be responsible to pay the tuition rate established by the State of New Jersey to the River Dell Board of Education for each student attending school in the River Dell Regional School District until residency has been established.

The person signing this Affidavit understands that any false statements, answers or declaration contained in this Affidavit may subject the affiant to criminal prosecution for the crime of false swearing in violation of N.J.S.A. 2C: 28-2. If a person is convicted of such a crime, he or she may be punished by a fine of up to $7,500.00, or be imprisoned for up to 18 months, or both.

_____ _____

Signature of Parent/Guardian Signature of "Affidavit Host" *(if applicable)*

Notary must NOT be employed by the River Dell Regional School District.

Subscribed and sworn to before me
This _____ day of _____, 20__ __
(Signed) _____
Notary Public of _____
Commission Expires _____

MUST BE NOTARIZED

River Dell Regional School District

230 Woodland Avenue, River Edge, NJ 07661

HOME LANGUAGE SURVEY

This form is available in other languages upon request.

STUDENT INFORMATION

Student Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Student's Birth Date: _____ Phone Number: _____

Date Entered the U.S.: _____

INTRODUCTION

This survey is the first of three steps to identify whether a student is eligible to be an English Language Learner (ELL).

Start with "Question 1" and continue until the form is complete. Select the answer for each question.

SURVEY QUESTIONS

Question 1 - What was the first language used by the student? _____

Question 2 - At home, does the student hear or use a language other than English more than half of the time?

_____ **YES** _____ **NO**

Question 3 - Does the student understand a language other than English?

_____ **YES** _____ **NO**

Question 4 - When interacting with his/her parents or guardians, does the student use a language other than English more than half of the time?

_____ **YES** _____ **NO**

Question 5 - When interacting with caregivers other than their parents or guardians, does the student use a language other than English more than half of the time?

_____ **YES** _____ **NO**

Question 6 - Has the student recently moved from another school district/charter school where he/she was identified as an English Language Learner?

_____ **YES** _____ **NO**

If you answered YES to these questions, please indicate the student's home language: _____

Thank you!

River Dell Regional School District

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www.riverdell.org

Office of the Superintendent

Dr. James, J. Albro **201-599-7206**

SUPERINTENDENT OF SCHOOLS **Fax: 201-261-3809**

STUDENT RECORDS RELEASE

To Whom It May Concern:

The following student(s) has/have enrolled in the River Dell Regional School District:

NAME	DATE OF BIRTH	GRADE

Please forward to the school indicated:

- Official Transcript of Credits
- Original A-45 health records
- Test scores
- Current grades
- Personal data that may be helpful
- **Child Study Team records (if applicable) MUST BE MAILED SEPARATELY** ⇨

☐ **RIVER DELL MIDDLE SCHOOL**
Attn: Guidance Department
230 Woodland Avenue
River Edge, NJ 07661

☐ **RIVER DELL REGIONAL HIGH SCHOOL**
Attn: Guidance Department
55 Pyle Street
Oradell, NJ 07649

☐ **RIVER DELL REGIONAL HIGH SCHOOL**
Attn: Mr. James Cooney, Director
55 Pyle Street
Oradell, NJ 07649

IF YOU ARE A NEW JERSEY PUBLIC SCHOOL:

1. **On the NJSMART website, please**:
   a. release student's State Identification #
   b. enter an EXIT CODE.
2. **Indicate student's New Jersey SID #:** ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Thank you for your assistance.

Sincerely,

Nancy Boettger

Nancy Boettger
District Registrar

THE RELEASE MUST BE COMPLETED BY PARENT/GUARDIAN.

STUDENT RECORDS RELEASE

I hereby give permission to release all past and present Medical, Educational, Academic, Discipline, and Special Services records, including the student's New Jersey SID Number, if applicable, pertaining to the student(s) noted above:

Name of Previous School Attended: _____

Street Address: _____

City, State, Zip Code: _____

School Fax No.: _____

School Email Address: _____

Guidance Dept. Telephone Number: _____

_____ _____

Parent/Guardian Signature **Date**

River Dell Regional School District

230 Woodland Avenue, River Edge, NJ 07661

IMPORTANT!

MUST BE COMPLETED PROMPTLY!

COMMUNITY PASS – *Must be completed BEFORE the laptop will be issued.*

Community Pass is a convenient way to complete district forms and pay fees:

1. You will receive an email from **info@communitypass.net**. The email will contain your username, temporary password and the Community Pass link.

2. Mandatory LAPTOP INSURANCE fee - $75 per school year.

3. Optional ACTIVITY fee for participation in clubs/sports:
    - Middle School: $50 per year
    - High School: $75 per year

Incoming 7th graders from Oradell and River Edge will receive this information via email over the summer.

GENESIS PARENT PORTAL

The Genesis Parent Portal offers you personalized access to our student information system, where you will view your student's gradebook by teacher, progress reports, report cards and attendance records.

- You will receive an email from **GenesisHelp@riverdell.org**. The email will contain your username and a temporary password.

Incoming 7th graders from Oradell and River Edge will receive this information via email over the summer.

Questions may be directed to **help.register@riverdell.org**.

Additional information may be obtained from your student's School Counselor.

/nmb

River Dell Regional School District

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Office of the Superintendent

Dr. James J. Albro **201-599-7206**

SUPERINTENDENT OF SCHOOLS **Fax: 201-261-3809**

MANDATORY

MEDICAL FORMS FOR REGISTRATION

New Jersey Department of Education
P.L. 2013, c.71

I. Preparticipation Physical Evaluation consists of the following four forms:

1. History Form
2. The Athlete with Special Needs Supplemental History Form
3. Physical Examination Form
4. Clearance Form
5. **IMMUNIZATIONS – please obtain a print out from your doctor's office.**

II. The following forms are provided for your convenience, *only necessary if they apply to your student:*

1. Asthma Treatment Plan Form
2. Food Allergy & Anaphylaxis Emergency Care Plan Form
3. Administering Medication Permission Forms (by School Nurse and Student)

Thank you!

ATTENTION PARENT/GUARDIAN: The preparticiaption 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 keep a 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 ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease 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 practician 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 _____

Address _____ Phone _____

Signature of physician, APN, PA _____

HE0503 9-2681/0410

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

Asthma Treatment Plan – Student

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

PACNJ Pediatric/Adult Asthma Coalition

Sponsored by American Lung Association in New Jersey

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 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.

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:**
  - ❖ **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 _____

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

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:_____

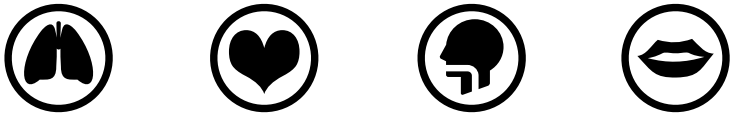
THEREFORE:

☐ 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

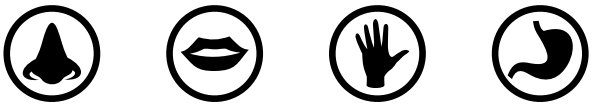
OTHER
Feeling something bad is about to happen, anxiety, confusion

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

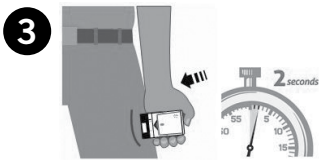
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

FARE
Food Allergy Research & Education

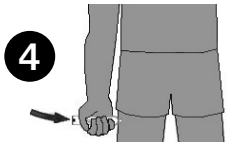
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

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.



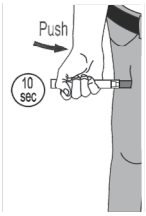
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

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

River Dell Regional Board of Education

230 Woodland Avenue
River Edge, NJ 07661

ADMINISTERING MEDICATION – (By School Nurse)

Part I - Prescribing Health Care Provider's Orders for Administration of Medication
(to be completed by prescribing health care provider)

In order to protect the health of your student, _____, it will be necessary for him/her to have medication during school hours prescribed as follows:

- Does the student have asthma or another potentially life-threatening illness or a life-threatening allergy?
  _____YES _____ NO

- If yes, is the student capable of and has the student been instructed in the proper method of self-administration of medication?
  _____ YES _____ NO

Name of Medication: _____

Dosage: _____

What specific time is medication to be administered: _____

Purpose of Medication: _____

What adverse reaction might occur if medication is taken over an extended period of time: _____

_____

What adverse reaction may occur if the medication is not administered according to the specified time set forth above: _____

_____

Please advise parents that medication must be provided by parents in original container.

_____
Signature of Health Care Provider

_____
Please Print Name

_____
Street Address

_____
City, State, Zip Code

_____
Telephone

_____
Date

River Dell Regional Board of Education

230 Woodland Avenue
River Edge, NJ 07661

ADMINISTERING MEDICATION – (By School Nurse)

Part II – Parent/Guardian Consent
(to be completed by parent/guardian)

Dear _____,

I hereby request that my student, _____, who attends Grade _____ at River Dell _____ School be administered medication during school hours as prescribed by her/his health care provider. I understand that the ultimate responsibility of medication is mine. I shall provide the prescribed medication in the original container. I understand that my request for the administration of medication during school hours to my student is effective for this school year only and must be renewed on an annual basis.

I understand and acknowledge that the River Dell Regional Board of Education and its employees and/or agents, including the school nurse and any delegates, shall incur no liability as a result of any injury arising from the administration of medication to my student, the self-administration of medication by my student, the administration of epinephrine to my student via a pre-filled auto-injection mechanism, or the administration of glucagon to my student and agree to indemnify and hold harmless the River Dell Regional Board of Education and its employees and agents, including the school nurse and delegates, against any and all claims arising from the administration of medication to my student, the self-administration of medication by my student and/or the administration of epinephrine to my student via a pre-filled auto-injector mechanism, or the administration of glucagon to my student.

_____
Signature of Parent/Guardian

_____
Please Print Name

_____
Date

River Dell Regional Board of Education

230 Woodland Avenue
River Edge, NJ 07661

ADMINISTERING MEDICATION – (By Student)

Part I – Self-Medication Permission Form
(to be completed by parent/guardian)

This information sets forth parent/guardian responsibilities regarding the self-administering student and also meets the requirements set forth in N.J.S.A. 18A:40-12.3(a)(3) that a Board of Education must inform parents/guardians of the self-medicating student that it will incur no liability as a result of any injury arising from the student's self medication.

A new authorization is to be submitted each school year.

General Instructions

1. A current, pre-filled auto-injector mechanism for epinephrine must be provided to the school for your student's use. All antihistamines, glucagon and/or other medication must be brought to school by the parent/guardian and be provided in the original container. Parents/guardians are responsible for replacing all expired medication.

2. The parent/guardian is responsible for having the attached Medical Certification completed by the student's treating physician.

3. This form must be completed every school year.

4. Please be advised that the River Dell Regional Board of Education and its employees or agents, including the school nurse and any delegates, shall incur no liability as a result of any injury arising from the administration of medication to student, the self-administration of medication by a student, the administration of epinephrine via a pre-filled auto-injector mechanism, and/or the administration of glucagon**.**

My student, _____, who attends grade _____ at the _____School has asthma, another potentially life-threatening illness, or a life-threatening allergic reaction. Therefore, I request that my student be allowed to self administer medication during school hours as prescribed by his/her physician. I hereby certify that my student is capable of, and has been instructed in, the proper method of self administration of medication by his/her health care provider.

I understand and acknowledge that the River Dell Regional Board of Education and its employees and/or agents, including the school nurse and any delegates, shall incur no liability as a result of any injury arising from the administration of medication to my student, the self-administration of medication by my student, the administration of epinephrine to my student via a pre-filled auto-injection mechanism, or the administration of glucagon to my student and agree to indemnify and hold harmless the River Dell Regional Board of Education and its employees and agents, including the school nurse and delegates, against any and all claims arising from the administration of medication to my student, the self-administration of medication by my student and/or the administration of epinephrine to my student via a pre-filled auto-injector mechanism, or the administration of glucagon to my student.

_____
Signature of Parent/Guardian

_____
Please Print Name

_____
Date

River Dell Regional Board of Education

230 Woodland Avenue
River Edge, NJ 07661

ADMINISTERING MEDICATION – (By Student)

Part II – Medical Certification
(to be completed by prescribing health care provider)

Name of Student: _____

Name of Medication: _____

Dosage: _____

Frequency and Directions: _____

_____

_____

_____ *I certify that the above-name student has:* ☐ *Asthma, or*
☐ *a potentially life-threatening illness, or*
☐ *a life-threatening allergy*
and is capable of, and has been instructed in, the proper method of self-administration of the following medication: _____.

_____ *I certify that the above-named student requires the administration of epinephrine for anaphylaxis.*

_____ *I certify that the above-named student requires the administration of glucagon for severe hypoglycemia.*

_____
Signature of Health Care Provider

_____
Please Print Name

_____
Street Address

_____
City, State, Zip Code

_____
Telephone

_____
Date