

PUBLIC SCHOOLS OF EDISON TOWNSHIP
EDISON, NEW JERSEY 08837
HEALTH SERVICES

HEALTH INFORMATION FOR FIELD TRIPS

Student Name _____ Social Security # (optional): _____
Home address: _____ Date of Birth: _____
Homeroom: _____ Grade: _____ Age: _____ Male: _____ Female: _____
Destination of Trip: _____ Date(s) of Trip: _____
Trip Advisor / Teacher: _____

Emergency Contact Person(s)*

1. Mother/Guardian: _____ Home phone: _____
Work phone: _____ Beeper/Cell phone: _____
2. Father/Guardian: _____ Home phone: _____
Work phone: _____ Beeper/Cell phone: _____
3. Other Contact Person: _____ Home phone: _____
Work phone: _____ Beeper/Cell phone: _____
4. Physician Name: _____ Phone: _____

*** Please make sure these persons CAN BE REACHED THE DAY(S) OF THE TRIP.**

Did you purchase school insurance policy for current school year? _____ Yes _____ No

Is there any health-related condition or medication which may need special consideration during the field trip?
_____ No _____ YES (please specify below)

Condition / medication(s) _____

- If there is a significant health-related condition which may need special consideration during the field trip, please make every attempt to be a trip chaperone. If student's safety cannot be arranged and assured, student may not be able to attend.
- Students are allowed to self-administer asthma inhalers or EpiPen ONLY, providing there is physician and parent permission on file for the current school year. Contact the School Nurse for appropriate district forms to be completed
- ALL MEDICATIONS (prescription and over-the-counter) require current physician order and parent permission on file. Medication Must be in original labeled container or packaging. Contact School Nurse for district medication administration form.
- CONTACT THE SCHOOL NURSE IMMEDIATELY IF ANY HEALTH CONCERNS.

Is there any reason that your student may not participate fully in the field trip activities?
_____ No _____ Yes (please specify below)

Explain limitation(s): _____

PARENT / GUARDIAN AUTHORIZATION
The above information is correct to the best of my knowledge, and my student can engage in all field trip activities unless noted above. In case of emergency and I cannot be reached, I give permission to the physician or hospital selected by the school representative to secure proper treatment and medical care (e.g.: medication, anesthesia, surgery, etc.) in case of emergency or as specified above for my student.

Signature of Parent / Guardian _____ Date

HEALTH HISTORY UPDATE (Must be completed)

Please check **YES** or **NO** for the following health information concerning your student. Be sure to include any **recent** (past 6-12 months) injuries, illnesses, or surgery that is in the student's health history which **could influence** their class trip activity participation or needs.

	<u>YES</u>	<u>NO</u>	<u>SPECIFICS</u>
Allergy (environmental, food, medication, etc.)	_____	_____	_____
Arthritis / joint or bone condition	_____	_____	_____
Asthma / Reactive Airway Disease	_____	_____	_____
Bleeding / blood disorder (e.g.: anemia, hemophilia, sickle cell disease, etc.)	_____	_____	_____
Communicable disease / condition or recent exposure (e.g.: strep, head lice, chicken pox, pink eye, impetigo, ringworm, etc.)	_____	_____	_____
Developmental condition / consideration (e.g.: ADHD, Down's Syndrome, Autism, brain injury, etc.)	_____	_____	_____
Diabetes	_____	_____	_____
Digestive / stomach condition	_____	_____	_____
Dental / orthodontic appliance or other prosthesis	_____	_____	_____
Eyeglasses / contacts / vision loss	_____	_____	_____
Fainting / lightheaded episodes / heat sensitivity	_____	_____	_____
Hearing loss	_____	_____	_____
Heart condition or chest pain with exercise	_____	_____	_____
High blood pressure	_____	_____	_____
Seizure disorder	_____	_____	_____
Immune system disorder (e.g.: mono, chronic fatigue syndrome, chemotherapy, etc.)	_____	_____	_____
Menstrual disorder / difficulties	_____	_____	_____
Significant fears / phobias	_____	_____	_____
Sleepwalking or sleep time difficulties	_____	_____	_____
Orthopedic condition, recent injury, back pain	_____	_____	_____
Other (<i>please specify</i>)	_____	_____	_____
Date of most recent tetanus shot, <i>if known</i>	_____	_____	_____

Please specify any dietary needs:

_____ Vegetarian _____ No milk / dairy _____ Food Allergy _____ Other

* Some conditions above may require physician clearance to participate.

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MEDICATION FOR OVERNIGHT TRIPS/ACTIVITIES

Dear Parent/Guardian:

The following over-the-counter medications are covered under the orders of the Edison Township district school physician. These medications may be given by the designated district nurse only if needed during overnight trips or activities. They will be administered **ONLY** according to the labeled indication(s) and dosage(s).

Please place an "X" next to the specific over-the-counter medication(s) you want given to your child if needed during the trip/activity time only.

Over-the-Counter Medications

- ___ ibuprofen (eg: Advil)
- ___ acetaminophen (eg: Tylenol)
- ___ Children's Mylanta/Mylanta
- ___ loperamide (eg: Imodium AD)
- ___ diphenhydramine (eg: Benadryl)

Student: _____ Grade: _____ School: _____

I hereby give my permission for the designated district nurse to administer to my student, the medications marked by an "X" above. I understand that these medications may be given **ONLY** according to the labeled indication(s) and dosage(s), as per the current Edison Township district school physician order.

I release school personnel of all liability for the administration of medication as specified above, during the trip/activity date(s): _____ (specify dates).

 Signature of Parent/Guardian

 Date

****ALL OTHER MEDICATIONS NEED PHYSICIAN ORDER & PARENT PERMISSION ON FILE WITH THE SCHOOL NURSE 20 SCHOOL DAYS PRIOR TO TRIP/ACTIVITY START.**

****All labeled container medications must be submitted to the school nurse minimally TWO SCHOOL DAYS PRIOR to the day of the trip or activity.**

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 HEALTH SERVICES

MEDICATION ADMINISTRATION PERMISSION

Dear Parent/Guardian:

All medication, prescription or OTC (over the counter) shall be administered only upon written order of the prescribing physician and a written request of the parent. This will give permission for the nurse to administer the medication as directed.

Medication must be given to the nurse only in a currently labeled prescription bottle or OTC labeled packaging.

PLEASE REVIEW THE ENTIRE MEDICATION POLICY #5141.21 ON THE REVERSE SIDE OF THIS FORM.

TO BE COMPLETED BY PHYSICIAN

Student: _____ Date: _____

Diagnosis/Purpose: _____

Name of Medication: _____

Dose: _____

Specific time(s) to be given: _____ (Daily or PRN) (circle one) AM / PM

Special circumstances of administration (if PRN, specify frequency): _____

Dates of Administration: _____

Specify **reportable** side effects: _____

 Name of Physician (**print**)

 Signature of Physician

 Address of Physician

 Date

(_____) _____
 Telephone # of Physician

TO BE COMPLETED BY PARENT/GUARDIAN

Student: _____ Date: _____

I hereby give permission to the school nurse to administer medication to my child as directed by the physician. I release school personnel of all liability for the administration of medication as specified above.

 Signature of Parent/Guardian

 Date

EDISON BOARD OF EDUCATION
EDISON, NEW JERSEY

ADMINISTERING MEDICATION

The board shall not be responsible for the diagnosis and treatment of pupil illness. The administration of prescribed medication to a pupil during school hours will be permitted only when failure to take such medicine would jeopardize the health of the pupil, or the pupil would not be able to attend school if the medicine were not made available to him/her during school hours. For purposes of this policy, "medication" shall include all medicines, prescribed by a physician advanced practice nurse, or physician assistant for the particular pupil. Including emergency medication such as Epi-Pens in the event of anaphylaxis or inhalers/nebulizers in the event of an asthma attack.

Before any medication may be administered to or by any pupil during school hours, the board shall require the written request of the parent/guardian which shall give permission for such administration and relieve the board and its employees of liability for administration of medication. In addition, the board requires the written order of the prescribing physician which shall include:

- A. The purpose of the medication;
- B. The dosage;
- C. The time at which or the special circumstances under which medication shall be administered;
- D. The length of time for which medication is prescribed;
- E. The possible side effects of the medication.

Both documents shall be kept on file in the office of the school nurse.

The district medical inspector shall develop procedures for the administration of medication which provide that:

- A. All medications whether prescribed or over the counter shall be administered by the school nurse, the parent/guardian or the pupil himself/herself where the parent/guardian so permits and the school nurse is present; in an emergency, an administrator may administer medication; other school employees trained and delegated by school nurse may administer epinephrine via Epi-Pen.
- B. Medications shall be security stored and kept in the original labeled container;
- C. The school nurse shall maintain a record of the name of the pupil to whom medication may be administered, the prescribing physician, the dosage and timing of medication and a notation of each instance of administration;
- D. All medications shall be brought to school by the parent/guardian or adult pupil and shall be picked up at the end of the school year or the end of the period of medication, whichever is earlier;
- E. A student may self-administer medication without supervision of the school nurse for asthma, anaphylaxis, or other life-threatening illness.
- F. The school nurse shall maintain an emergency care plan for students with life threatening illnesses requiring the administration of medication.

EDISON BOARD OF EDUCATION
EDISON, NEW JERSEY 08837
HEALTH SERVICES

PARENT/GUARDIAN AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATION

School: _____ School Year: _____

Grade/Level: _____ Homeroom: _____

1. We/I (Circle), the undersigned parents(s)/guardian(s) (Circle) of _____
(Name of student)

authorize the Edison Board of Education to permit our child to carry on his/her person and self-administer his/her own medication identified as follows:

(Name of Medication)

2. Attached hereto is the Asthma Action Plan written certification of _____
(Name of Healthcare Provider)

healthcare provider for the child noted above that the child has asthma, which is a potentially life-threatening illness. Our child is capable of, and has been instructed in, the proper method of self-administration of the medication identified above.

3. I/We (Circle) acknowledge that the Edison School District shall incur no liability as a result of any injury arising from the self-administration of medication(s) by the child noted above and I/We (Circle) shall identify and hold harmless the Edison School District and its employees or agents against any claims arising out of the self-administration of medication by the child noted above.

4. This authorization is effective for the 20__ - 20__ school year.

(Print name of parent/guardian)

(Print name of parent/guardian)

(Signature of parent/guardian)

(Signature of parent/guardian)

(Date)

5. I take responsibility for proper use and safe handling of my medication. I understand that improper or unsafe use or handling of medication may revoke my self-administration privileges.

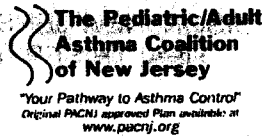
Student signature: _____

Date: _____

Student is responsible for safe and appropriate self-administration of medication.
Asthma medication self-administration may be denied if safety for self or others is compromised.

Asthma Treatment Plan

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



(Please Print)

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

HEALTHY



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 medicine(s). All metered dose inhalers (MDI) to be used with spacers.

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
<input type="checkbox"/> Advair® 100, 250, 500	1 inhalation twice a day
<input type="checkbox"/> Advair® HFA 45, 115, 230	2 puffs MDI twice a day
<input type="checkbox"/> Asmanex® Twisthaler® 110, 220	1 - 2 inhalations a day
<input type="checkbox"/> Flovent® 44, 110, 220	2 inhalations twice a day
<input type="checkbox"/> Flovent® Diskus® 50 mcg	1 inhalation twice a day
<input type="checkbox"/> Pulmicort Flexhaler® 90, 180	1 - 2 inhalations once or twice a day
<input type="checkbox"/> Pulmicort Respules® 0.25, 0.5, 1.0	1 unit nebulized once or twice a day
<input type="checkbox"/> Qvar® 40, 80	2 inhalations twice a day
<input type="checkbox"/> Singulair 4, 5, 10 mg	1 tablet daily
<input type="checkbox"/> Symbicort® 80, 160	2 puffs MDI twice a day
<input type="checkbox"/> Other	

Remember to rinse your mouth after taking inhaled medicine.

If exercise triggers your asthma, take this medicine _____ minutes before exercise.

CAUTION



You have any of these:

- Exposure to known trigger
- Cough
- Mild wheeze
- Tight chest
- Coughing at night
- Other: _____

And/or Peak flow from _____ to _____

Continue daily medicine(s) and add fast-acting medicine(s).

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
<input type="checkbox"/> Accuneb® 0.63, 1.25 mg	1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Albuterol 1.25, 2.5 mg	1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Albuterol <input type="checkbox"/> Pro-Air <input type="checkbox"/> Proventil®	2 puffs MDI every 4 hours as needed
<input type="checkbox"/> Ventolin® <input type="checkbox"/> Maxair <input type="checkbox"/> Xopenex®	2 puffs MDI every 4 hours as needed
<input type="checkbox"/> Xopenex® 0.31, 0.63, 1.25 mg	1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Increase the dose of, or add:	

➔ If fast-acting medicine is needed more than 2 times a week, except before exercise, then call your doctor.

EMERGENCY



Your asthma is getting worse fast:

- Fast-acting medicine did not help within 15-20 minutes
- Breathing is hard and fast
- Nose opens wide
- Ribs show
- Trouble walking and talking
- Lips blue • Fingernails blue

And/or Peak flow below _____

Take these medicines NOW and call 911. Asthma can be a life-threatening illness. Do not wait!

<input type="checkbox"/> Accuneb® 0.63, 1.25 mg	1 unit nebulized every 20 minutes
<input type="checkbox"/> Albuterol 1.25, 2.5 mg	1 unit nebulized every 20 minutes
<input type="checkbox"/> Albuterol <input type="checkbox"/> Pro-Air <input type="checkbox"/> Proventil®	2 puffs MDI every 20 minutes
<input type="checkbox"/> Ventolin® <input type="checkbox"/> Maxair <input type="checkbox"/> Xopenex®	2 puffs MDI every 20 minutes
<input type="checkbox"/> Xopenex® 0.31, 0.63, 1.25 mg	1 unit nebulized every 20 minutes
<input type="checkbox"/> Other	

Triggers

Check all items that trigger patient's asthma:

- Chalk dust
- Cigarette Smoke & second hand smoke
- Colds/Flu
- Dust mites, dust, stuffed animals, carpet
- Exercise
- Mold
- Ozone alert days
- Pests - rodents & cockroaches
- Pets - animal dander
- Plants, flowers, cat grass, pollen
- Strong odors, perfumes, cleaning products, scented products
- Sudden temperature change
- Wood Smoke
- Foods: _____

Other: _____

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

EFFECTIVE MARCH 2008
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Approved by the New Jersey Throat Society

FOR MINORS ONLY:

- This student is capable and has been instructed in the proper method of self-administering of the inhaled medications named above in accordance with NJ Law.
- This student is not approved to self-medicate.

PHYSICIAN/APN/PA SIGNATURE _____ DATE _____

PARENT/GUARDIAN SIGNATURE _____

PHYSICIAN STAMP

Make a copy for patient and for physician file. For children under 18, send original to school nurse or child care provider.