**Please make sure to visit
Metuchenschools.org

Click on
NEW STUDENT REGISTRATION

Then click on Open Registration Link
When you complete the online registration –print out the confirmation

METUCHEN SCHOOL DISTRICT

16 Simpson Place
Metuchen, New Jersey 08840

Office Use Only
AM 8:45-11:40AM
or
PM 12:25-3:20PM
ROOM_____

Rick Cohen
Principal/Assistant Superintendent

732 321-8700, ext. 2000
FAX (732) 321-1285

Students Name_____ **Date:**_____
Address_____ **Phone**_____ **Date of Birth**_____

Does the Student have Siblings in the school district? ____ **Yes**_____ **No**_____

Student is NOT REGISTERED until ALL documents are complete.

1. _____ **SIGNED ONLINE CONFIRMATION PAGE****
2. _____ **Copy of Original BIRTH CERTIFICATE** WITH GUARDIAN DRIVER'S LICENSE ON TOP
3. _____ **TWO (2) PROOFS OF RESIDENCY**
   - _____ **1. DEED/PROPERTY TAX BILL OR _____ LEASE**
   - _____ **2. UTILITY BILL**
   - ___3. If living with relative _____ Notarized Affidavit-print from Metuchen Schools Website(owner must provide 1-3)
   - ___4. Family living with owner must also provide proof of residency, Bank Statement, Insurance, or Drivers license at same address. If living with Renter-lease must be updated to show new tenants along with notarized Affidavit.
4. _____ **REGISTRATION QUESTIONAIRE FORM**
5. _____ **EMERGENCY INFORMATION FORM (2 SIDED)**
6. _____ **MEDIA RELEASE FORM**
7. _____ **IMMUNIZATION RECORD & PHYSICAL EXAM**
   Within 6 months
8. _____ **STUDENT LIVES WITH _____ CUSTODY RECORDS_____**

Please bring original birth certificates for registrar appointment in April

Guardian and Student must be present for registration.

- **Registration; BY APPOINTMENT ONLY-we will send a scheduler form in April**
- **ALL FORMS MUST BE PRESENTED AT REGISTRATION APPOINTMENT**

Moss School Secretary, Trisch Hallas 732 321-8700 ext 2000 phallas@metboe.k12.nj.us
Moss School Nurse, Nga Pham732 321-8700 ext 2003 npham@metboe.k12.nj.us

METUCHEN PUBLIC SCHOOLS
Metuchen Board of Education
16 Simpson Place, Metuchen, NJ 08840
Student Registration Process
732-321-8700 ext. 2000

Moss School Student Registration Form

All information on this form must be completed, including presentation of required documents prior to enrolling in school. Please use one form for each child.

Date: _____

Student: _____
Last Name First Name Middle Name

Date of Birth: _____ Place of Birth: _____
City State Country

Grade: _____ Age: _____ Sex: ____ Primary Language Spoken In Home: _____

☐ ***Hispanic*** ☐ ***White*** ☐ ***Black***

☐ ***American Indian/Alaskan*** ☐ ***Asian*** ☐ ***Hawaiin Native/Other Pacific Islander*** ☐ ***Multi-Racial***

***Student lives with:** ☐ **Parent(s)** ☐ **Mother** ☐ **Father** ☐ **Guardian** ☐ **Other**

Home Address: _____ Home Phone: _____

_____ Cell Phone: _____

PARENT/GUARDIAN INFORMATION

Legal Guardian 1: _____ Work Phone: _____

Email: _____ Cell Phone: _____

Employer's Name/Address: _____

Relationship to Student:_____

Legal Guardian 2: _____ Work Phone: _____

Email: _____ Cell Phone: _____

Employer's Name/Address: _____

Relationship to Student:_____

SECOND PARENT WITH DIFFERENT ADDRESS (If applicable)

Second Parent's Name			
Street Address	**City**	**State**	**Zip**

ADDITIONAL QUESTIONS:

If the student's parents are domiciled in different districts, regardless of which parent has custody, please answer the following questions:

Is there a court order or written agreement between the parents designating the district for school attendance, and if so, where does it require the student to attend school? (You will be asked to provide a copy of this document.)_____

_____

_____

Does the student reside with one parent for the entire year? If so, with which parent and at what address? _____

_____

_____

If not, for what portion of time does the student reside with each parent and at what addresses?___

_____

_____

_____

If the student lives with both parents on an equal-time, alternating week/month or other similar basis, with which parent did the student reside on the last school day prior to October 16 preceding the date of this application? _____

_____

Children in Family (including student) in order of age – Oldest (first) to youngest

Name	Grade	DOB	Sex

STATEMENT OF CERTIFICATION

I certify that the information provided in this form is true and accurate. I understand that misrepresenting myself as a legal resident of Metuchen may result in criminal prosecution or legal attempts to collect tuition.

_____ _____

Signature(s) of Parent(s)/Guardian(s) completing this form **Date**

PREVIOUS PRESCHOOL INFORMATION

Country, if outside the US: _____

Name of School _____
Circle One
Full Day AM Half Day PM Half Day

Street Address	**City**	**State**	**Zip**
Teacher Name	**Class Number**		

Student Name: _____

I authorize release of student records and information to a representative of Moss School,

Parent Signature_____

Date_____

METUCHEN SCHOOL DISTRICT **side 1**
EMERGENCY INFORMATION FORM

Office Use Only: TEACHER _____ GRADE_____ AM/PM

Dear Parents/Guardians:

It may be necessary to contact you during school hours because of a sudden illness or accident. Please provide both sides with the following information so that school personnel can reach you as soon as possible.

CHILD'S NAME _____

HOME ADDRESS _____ PHONE# _____

MOTHER'S CELL# _____

FATHER'S CELL# _____

MOTHER/GUARDIAN _____ WORK# _____

BUSINESS ADDRESS _____

FATHER/GUARDIAN _____ WORK#_____

BUSINESS ADDRESS _____

FAMILY PHYSICIAN _____ PHONE _____

ADDRESS _____

In case of an extreme medical emergency where the school is unable to reach you, whom do you designate to assume the responsibility for your child?

Name _____ Relationship _____

Address _____ Phone_____

Please note that in the event you cannot be reached and school personnel find it necessary to contact your family doctor, you will assume full responsibility for the costs of his/her services.

_____ _____
(Parent's/Guardian's signature) **(Date)**

Does child have Health Insurance?
Yes____If Yes, name of insurance company _____
No ____
NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents
For more information call 800-701-0710 or visit www.njfamilycare.org to apply on line.
You may release my name and address to the NJ FamilyCare Program to contact me about health insurance.
Signature:
_____PrintedName:_____Date:_____
Written consent required pursuant to 20 U.S.C. § 1232g (b) (1) and 34 C.F.R. 99.30 (b).

(over)

Emergency Information Form
Side 2

Telephone Chain for Emergency Early Dismissal

I give permission to the school to release a photocopy of this side of the form to a class parent. I understand that if there is an emergency early dismissal at Moss School, someone will try to call me first. If I cannot be reached, one of my emergency contacts (listed below) will be notified.

_____ _____
(Parent's/Guardian's signature) (Date)

CHILD'S NAME _____

NAME OF PARENT TO BE CALLED FIRST _____

PHONE # WHERE PARENT CAN BE REACHED _____

Please indicate at least 2 other people (one must live locally) who have agreed to be an emergency contact for your child. They must be prepared to tell the caller:

- **How your child will get home (on the YMCA bus or be picked up at Moss School)**
- **Who will come to pick your child up at the school**

NOTE: Emergency contacts need to be available to come for the child if neither parent is at home.

Please list your contacts in the order you want them to be called:

	NAME	PHONE NUMBER	RELATION TO STUDENT
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

_____ _____
(Parent's/Guardian's signature) (Date)

Metuchen Public Schools
Media Release Form

Throughout the school year, the school district publishes information highlighting student accomplishments as well as information about the programs and features of a particular school. Most of this information is available on our website (district and school) for public viewing as well. These publications can include student names, photographs, images, presentations, and recordings that are related to school or class activities. The media may include, but is not limited to, newspaper (print and electronic), local cable network, district and school websites, and local public relations sites. All information that is published is submitted to the superintendent or building principal, for review prior to publication.

However, because of student privacy laws, we want to secure parental permission before publishing information about any child. In the spirit of recognizing the achievements of our students, we print the student's name and/or photo and award titles. The school district controls what is distributed to the public in our publications and on our websites. We do not, however, control what is produced by outside media sources. Thus, we are sending you this parental consent form to both inform you and to request permission to include your child's photo/image and personally identifiable information in school/district related photographs, videos, and press releases, including those available on the district and/or school website.
As you are aware, there are potential dangers associated with the posting of personally identifiable information on a website since global access to the Internet does not allow us to control who may access such information. These dangers have always existed; however, we as schools do want to celebrate your child and his/her work. The law requires that we ask for your permission to use personally identifiable information about your child.

Pursuant to law, we will not release any personally identifiable information without prior written consent from you as parent or guardian. Personally identifiable information includes student names, photo or image, residential addresses, e-mail address, phone numbers and locations and times of class trips. If you, as the parent or guardian, wish to rescind your consent, you may do so at any time in writing by sending a letter to the principal of your child's school and such rescission will take effect upon receipt by the school. [If the student is an adult, this release form must be signed by the student and all references herein to "your child" shall refer to the adult student].

Parent-Signed Media Releases are <u>not needed</u> when:

- Photographing or videotaping anonymous students engaged in normal classroom/school activities.
- Photographing or videotaping students at events that are open to the public, such as music concerts, theater productions, or athletic events, first day of school, holiday parties, graduation.

_____ initial here

Please <u>check one</u> of the following choices:

- ❑ I/We GRANT permission to INCLUDE MY CHILD'S PHOTO/IMAGE and my child's FIRST NAME in school/district related photographs, videos, and press releases, including those available on the district and/or school website.
- ❑ I/We GRANT permission to INCLUDE MY CHILD'S PHOTO/IMAGE and my child's FULL NAME in school/district related photographs, videos, and press releases, including those available on the district and/or school website.
- ❑ I/We GRANT permission to INCLUDE MY CHILD'S PHOTO/IMAGE WITHOUT ANY OTHER PERSONAL IDENTIFIERS in school/district related photographs, videos, and press releases, including those available on the district and/or school website.
- ❑ I/We GRANT permission to INCLUDE MY CHILD'S PHOTO/IMAGE and ALL OTHER PERSONALLY IDENTIFIABLE INFORMATION in school/district related photographs, videos, and press releases, including those available on the district and/or school website.
- ❑ I/We DO NOT GRANT permission to include my child in school/district related photographs, videos, and press releases, including those available on the district and/or school website.

Student's Name (please print): _____ School_____

Print name of Parent/Guardian: (print)_____

Signature of Parent/Guardian: (sign) _____ Date_____

Metuchen School District

16 Simpson Place, Metuchen NJ 08840
Office of the Registrar
Nurse: p. 732-321-8700 x 2003 f. 732-321-8710

MEDICAL HISTORY FORM

To be completed by parent/guardian

Child's Full Name _____ DOB_____

Does your child have any chronic medical conditions, such as asthma, allergies, diabetes, ear infections, stomach problems, heart problems, etc.? If yes, please list:	☐YES ☐NO
Does your child take or has he/she been prescribed any medication, such as inhaler, EpiPen, vitamin? If yes, please list:	☐YES ☐NO
Has your child ever had any communicable diseases, including chicken pox? If yes, please list:	☐YES ☐NO
Does your child have any speech or hearing problems? If yes, please list services and frequency:	☐YES ☐NO
Has your child had any surgical procedures? If yes, please list (include place and date of the procedure, and follow-up date(s) if applicable):	☐YES ☐NO
Does your child wear eyeglasses or a patch? If yes, please list reason: Should anything be worn at school? ☐ Yes ☐ No	☐YES ☐NO

Thank you for your cooperation in sharing this important information about your child.

_____ _____

Parent Signature Date

APPENDIX H

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: *American Academy of Pediatrics, New Jersey Chapter*
New Jersey Academy of Family Physicians
New Jersey Department of Health

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name *(Last)* *(First)*	Gender ☐ Male ☐ Female	Date of Birth / /

Does Child Have Health Insurance? ☐Yes ☐No	If Yes, Name of Child's Health Insurance Carrier

Parent/Guardian Name	Home Telephone Number ( ) -	Work Telephone/Cell Phone Number ( ) -
Parent/Guardian Name	Home Telephone Number ( ) -	Work Telephone/Cell Phone Number ( ) -

I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Signature/Date	This form may be released to WIC. ☐Yes ☐No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:	Results of physical examination normal? ☐Yes ☐No

Abnormalities Noted:		
	Weight *(must be taken within 30 days for WIC)*	
	Height *(must be taken within 30 days for WIC)*	
	Head Circumference *(if <2 Years)*	
	Blood Pressure *(if ≥3 Years)*	

IMMUNIZATIONS	☐ Immunization Record Attached ☐ Date Next Immunization Due: _____

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐ None ☐ Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	☐ None ☐ Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☐ None ☐ Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐ None ☐ Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☐ None ☐ Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☐ None ☐ Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☐ None ☐ Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: ☐ Capillary ☐ Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

☐ ***I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.***

Name of Health Care Provider (Print)	Health Care Provider Stamp:
Signature/Date	

Instructions for Completing the Universal Child Health Record (CH-14)

Section 1 - Parent

Please have the parent/guardian complete the top section and sign the consent for the child care provider/school nurse to discuss any information on this form with the health care provider.

The WIC box needs to be checked only if this form is being sent to the WIC office. WIC is a supplemental nutrition program for Women, Infants and Children that provides nutritious foods, nutrition counseling, health care referrals and breast feeding support to income eligible families. For more information about WIC in your area call 1-800-328-3838.

Section 2 - Health Care Provider

1. Please enter the date of the physical exam that is being used to complete the form. Note significant abnormalities especially if the child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing etc.)
   - **Weight** - Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within the last 30 days.
   - **Height** - Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within the last 30 days.
   - **Head Circumference** - Only enter if the child is less than 2 years.
   - **Blood Pressure** - Only enter if the child is 3 years or older.

2. **Immunization** - A copy of an immunization record may be copied and attached. If you need a blank form on which to enter the immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Department of Health, Vaccine Preventable Diseases Program at 609-826-4860. The Immunization record must be attached for the form to be valid.
   - "Date next immunization is due" is optional but helps child care providers to assure that children in their care are up-to-date with immunizations.

3. **Medical Conditions -** Please list any ongoing medical conditions that might impact the child's health and well being in the child care or school setting.

   a. Note any significant medical conditions or major surgical history. **If the child has a complex medical condition, a special care plan should be completed and attached for any of the medical issue blocks that follow.** A generic care plan (CH-15) can be downloaded at www.nj.gov/health/forms/ch-15.dot or pdf. Hard copies of the CH-15 can be requested from the Division of Family Health Services at 609-292-5666.

   b. **Medications -** List any ongoing medications. Include any medications given at home if they might impact the child's health while in child care (seizure, cardiac or asthma medications, etc.). Short-term medications such as antibiotics do not need to be listed on this form. Long-term antibiotics such as antibiotics for urinary tract infections or sickle cell prophylaxis should be included.

      PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigger medication administration. *Please be specific about what over-the-counter (OTC) medications you recommend, and include information for the parent and child care provider as to dosage, route, frequency, and possible side effects. Many child care providers may require separate permissions slips for prescription and OTC medications.*

   c. **Limitations to physical activity -** Please be as specific as possible and include dates of limitation as appropriate. Any limitation to field trips should be noted. Note any special considerations such as avoiding sun exposure or exposure to allergens. Potential severe reaction to insect stings should be noted. Special considerations such as back-only sleeping for infants should be noted.

   d. **Special Equipment** – Enter if the child wears glasses, orthodontic devices, orthotics, or other special equipment. Children with complex equipment needs should have a care plan.

   e. **Allergies/Sensitivities -** Children with life-threatening allergies should have a special care plan. Severe allergic reactions to animals or foods (wheezing etc.) should be noted. Pediatric asthma action plans can be obtained from The Pediatric Asthma Coalition of New Jersey at www.pacnj.org or by phone at 908-687-9340.

   f. **Special Diets** - Any special diet and/or supplements that are medically indicated should be included. Exclusive breastfeeding should be noted.

   g. **Behavioral/Mental Health issues** – Please note any significant behavioral problems or mental health diagnoses such as autism, breath holding, or ADHD.

   h. **Emergency Plans -** May require a special care plan if interventions are complex. Be specific about signs and symptoms to watch for. Use simple language and avoid the use of complex medical terms.

4. **Screening** - This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public heath personnel to track children's health. Please enter the date that the test was performed. Note if the test was abnormal or place an "N" if it was normal.
   - For lead screening state if the blood sample was capillary or venous and the value of the test performed.
   - For PPD enter millimeters of induration, and the date listed should be the date read. If a chest x-ray was done, record results.
   - Scoliosis screenings are done biennially in the public schools beginning at age 10.

   This form may be used for clearance for sports or physical education. As such, please check the box above the signature line and make any appropriate notations in the Limitation to Physical Activities block.

5. Please sign and date the form with the date the form was completed (note the date of the exam, if different)
   - Print the health care provider's name.
   - Stamp with health care site's name, address and phone number.

Complete the following pages only if applicable.

FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergic to: _____

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

PLACE PICTURE HERE

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

Extremely reactive to the following allergens:_____

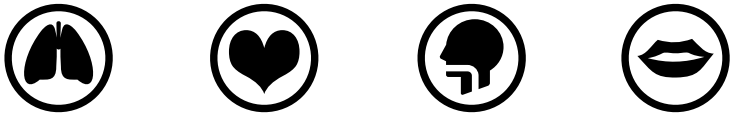
THEREFORE:

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

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

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS



LUNG
Shortness of breath, wheezing, repetitive cough

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

THROAT
Tight or hoarse throat, trouble breathing or swallowing

MOUTH
Significant swelling of the tongue or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

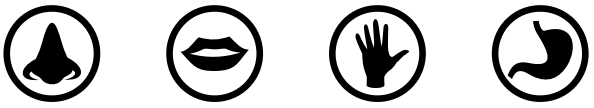
OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

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

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

MILD SYMPTOMS



NOSE
Itchy or runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea or discomfort

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

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

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

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

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

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

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

_____

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

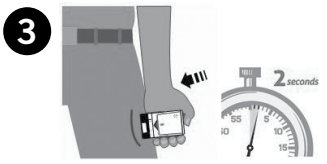
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

FARE
Food Allergy Research & Education

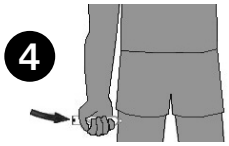
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

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



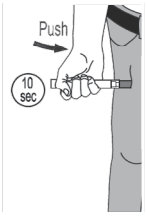
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

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



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

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



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

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

HOW TO USE SYMJEPI™ (EPINEPHRINE INJECTION, USP)

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

ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

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

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

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

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP:_____ PHONE: _____

NAME/RELATIONSHIP:_____ PHONE: _____

NAME/RELATIONSHIP:_____ PHONE: _____

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

Asthma Treatment Plan – Student

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

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

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