**Please make sure to visit
Metuchenschools.org
If New Student or Sibling
Click on
NEW STUDENT REGISTRATION

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

METUCHEN SCHOOL DISTRICT

16 Simpson Place
Metuchen, New Jersey 08840

PREFERENCE
____**AM** 9:10A-11:15A

____**PM** 11:55A-2:00P

____ **FULL DAY**
9:10A-2:00P (parent sends lunch)

Rick Cohen
Principal/Assistant Superintendent

732 321-8700, ext. 2000
FAX (732) 321-8710

INTEGRATED PRESCHOOL APPLICATION

Students Name_____Date:_____

Student is NOT REGISTERED until ALL documents are complete.

0. _____ **DRIVERS LICENSE**
1. _____ **SIGNED ONLINE CONFIRMATION PAGE** (NEW STUDENTS ONLY)**
2. _____ **CHILD'S Original BIRTH CERTIFICATE**

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. ____ Deposit $590(Half Day) _____ Deposit $1,180(Full Day)
Deposit covers Sep & Jun Monthly Payment
OCT-MAY = $295(Half Day) $590(Full Day)
Checks payable to: Metuchen Board of Education in Notation area write Preschool Deposit
Mail to:
16 Simpson Pl
Metuchen NJ 08840
Attention Trisch Hallas

Please Submit ALL documents should be submitted in ONE email to Trisch Hallas
Moss School Secretary, Trisch Hallas 732 321-8700 ext 2000 phallas@metboe.k12.nj.us
Moss School Nurse, Nga Pham 732 321-8700 ext 2003 npham@metboe.k12.nj.us

Student Must be Potty Trained

No busing

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

PREVIOUS SCHOOL *Country, if outside the US:* _____

Name of School			
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 of Guardian_____

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.

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
732 321-8700 Ext. 2003
FAX 732 321-8710

Medical History Form

To be completed by Parent/Guardian

Child's Full Name _____ Date of Birth _____

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 had any **surgical procedures**? If yes, please list (include place and date of the procedure, and follow-up date(s) if applicable):	☐ **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**
Does your child **wear eyeglasses or a patch**? If yes, please list condition: Should anything be worn at school? ☐ Yes ☐ No	☐ **Yes** ☐ **No**

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

I, _____ give permission to the school nurse to share pertinent medical information with school personnel.

_____ _____

Signature of Parent/Guardian Date

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TO BE COMPLETED BY PHYSICIAN

ROUTINE PHYSICAL EXAMINATION REPORT

STUDENT'S NAME: _____ GRADE: _____

DATE OF BIRTH: _____

PHYSICIAN OR PROVIDER INFORMATION – PLEASE COMPLETE BOTH SIDES

This section MUST be complete in order for this form to be accepted!

Height: _____ Blood Pressure: _____ Hearing: R: _____ L: _____

Weight: _____ Pulse: _____ bpm Vision: R: 20/ _____ L: 20/ _____

Correction: Y / N Contacts: Y / N Eyeglasses: Y / N

Indicators	Normal? (circle One)		Abnormal Findings/Comments
Head/Neck	YES	NO	
Eyes/ Sclera/Pupils	YES	NO	
Ears	YES	NO	
Nose/ Mouth/ Throat	YES	NO	
Heart: Murmurs/ Rhythms	YES	NO	
Lungs: Auscultation/Percussion	YES	NO	
Chest Contour	YES	NO	
Skin	YES	NO	
Abdomen: Assessment (inc. liver, spleen)	YES	NO	
Tanner Stage: Testes/Onset of Menses	YES	NO	
Hernia? (if yes/possible, please explain)	NEG	YES/ possible	
Neck/Back/Spine: Range of Motion	YES	NO	
Scoliosis:	NEG.	YES/ possible	
Upper Extremities	YES	NO	
Lower Extremities	YES	NO	
Neurological: Balance & Coordination:	YES	NO	
Romberg:	YES	NO	
Heel Walk:	YES	NO	
Tandem Walk:	YES	NO	
Nose Touch:	YES	NO	
Toe Walk:	YES	NO	

MAKE A COPY FOR YOUR CHILD'S HOME HEALTH FILE

**Continued on back of page

STUDENT'S NAME _____ **GRADE:**_____

PHYSICIAN OR PROVIDER MUST CONTINUE TO PROVIDE THE INFORMATION BELOW

Medications currently in use:
ATTACH COPY OF COMPLETE IMMUNIZATION RECORD.
Allergies: Yes / No LIST Allergies, if any:
Additional Comments:

General Diagnosis: _____

Recommendations: _____

_____

_____

EXAMINED BY: Health Care Provider _____

School Physician _____

I hereby certify that the above named student was examined by me and found physically fit to engage in all physical activity including physical education and recess.

Health Care Provider's Signature: _____

Circle ONE: MD DO NP PA

↑PLEASE STAMP WITH OFFICE STAMP↑

EXAMINATION DATE: _____

MAKE A COPY FOR YOUR CHILD'S HOME HEALTH FILE

IMMUNIZATIONS REQUIRED

FOR KINDERGARTEN

- 4 doses of **DPT**, with the 4th dose on or after the 4th birthday, or any 5 doses

  3 doses of **OPV/IPV (Polio)** with the 3rd dose on or after the 4th birthday or any 4 doses.

- 1 dose of **measles, mumps, and rubella vaccines** on or after the 1st birthday (Note: 1 dose of MMR vaccine satisfies this requirement.)

  1 dose of a **measles** containing vaccine on or after the 4th birthday. (Note: a second dose of MMR satisfies this requirement. Results of a blood test called a titer shows immunity to measles is also acceptable.

- 3 doses of **Hepatitis B vaccine**

- 1 dose of **varicella (chicken pox)** vaccine on or after the 1st birthday or proof of previous disease via parents note, physician's statement, or report of blood test showing immunity to chicken pox. Must show date of varicella disease.

***All immunizations must show the full date (month/day/year)**

by your doctor or nurse practitioner dated within 365 days of the start of school.

2. **Health History** form to be completed by parents or guardian.

Moss School Nurse

(732) 321-8700 x 2003

FAX 732 321-8710

NJ SCHOOL MINIMUM IMMUNIZATIONS REQUIREMENTS

FOR MIPP/PRESCHOOL

- 4 DOSES OF DPT VACCINE
- 3 DOSES OF POLIO VACCINE
- 1 DOSE OF HIB VACCINE
- 1 DOSE OF EACH –MEASLES, MUMPS AND RUBELLA VACCINES ON OR AFTER THE FIRST BIRTHDAY (1 DOSE OF MMR SATISFIES THIS REQUIREMENT)
- 3 DOSES OF HEPATITIS B VACCINE
- 1 DOSE OF PCV (PNEUMONIA) VACCINE
- 1 DOSE OF ANNUAL FLU VACCINATION TO BE GIVEN BETWEEN SEP 1ST & DEC 31ST OF EACH YEAR OF PRESCHOOL.

ALL IMMUNIZATION RECORDS MUST SHOW FULL DATE (MONTH/DAY/YEAR)

TIONAL REQUIREMENTS –

1 - PHYSICAL EXAM DONE BY A PHYSICIAN OR NURSE PRACTITIONER WITHIN 365 DAYS BEFORE ENTRY (FORM AVAILABLE ONLINE)

2 – HEALTH HISTORY FORM TO BE COMPLETED BY THE PARENT OR GUARDIAN (FORM AVAILABLE ONLINE)

MOSS SCHOOL NURSE

732 321-8700 EXT **2003**
FAX 732-321-8710

FILL OUT THE FOLLOWING FORMS ONLY IF IT APPLIES TO YOUR CHILD

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Asthma Treatment Plan – Student

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

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

Sponsored by American Lung Association

NJ Health

(Please Print)

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

HEALTHY (Green Zone)

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

And/or Peak flow above _____

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

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ 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.

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

REVISED AUGUST 2014

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 ____________

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

Sponsored by
AMERICAN LUNG ASSOCIATION IN NEW JERSEY

FARE FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

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

PLACE STUDENT'S PICTURE HERE

For a suspected or active food allergy reaction:

FOR **ANY** OF THE FOLLOWING

SEVERE SYMPTOMS

[ ] If checked, give epinephrine immediately if the allergen was definitely eaten, even if there are no symptoms.

LUNG
Short of breath, wheezing, repetitive cough

HEART
Pale, blue, faint, weak pulse, dizzy

THROAT
Tight, hoarse, trouble breathing/ swallowing

MOUTH
Significant swelling of the tongue and/or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting or severe diarrhea

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

OR A COMBINATION
of mild or severe symptoms from different body areas.

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. **Use Epinephrine.**

1. INJECT EPINEPHRINE IMMEDIATELY.

2. **Call 911.** Request ambulance with epinephrine.

- Consider giving additional medications (following or with the epinephrine):
  - Antihistamine
  - Inhaler (bronchodilator) if asthma
- Lay the student flat and raise legs. 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 student to ER even if symptoms resolve. Student should remain in ER for 4+ hours because symptoms may return.

NOTE: WHEN IN DOUBT, GIVE EPINEPHRINE.

MILD SYMPTOMS

[ ] If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/discomfort

⇩ ⇩ ⇩

1. GIVE ANTIHISTAMINES, IF ORDERED BY PHYSICIAN

2. Stay with student; alert emergency contacts.
3. Watch student closely for changes. If symptoms worsen, **GIVE EPINEPHRINE.**

MEDICATIONS/DOSES

Epinephrine Brand: _____

Epinephrine Dose: [ ] 0.15 mg IM [ ] 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., Inhaler-bronchodilator if asthmatic): _____

_____

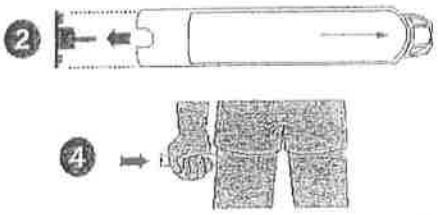
PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 8/2013

FARE FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

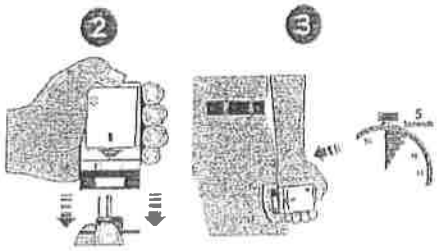
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

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



AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

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



ADRENACLICK®/ADRENACLICK® GENERIC DIRECTIONS

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

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

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

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE

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MOSS SCHOOL
KINDERGARTEN / PRESCHOOL
ALLERGIC REACTION / MEDICATION FORM

My child _____ has a potentially life – threatening allergy that could result in anaphylaxis. This student requires emergency administration of epinephrine by a pre-filled auto-injector mechanism containing epinephrine in the event of anaphylaxis in accord with P.L. 2007,c57.

In order to keep my child safe at school or a school sponsored event, I consent to the following for the 20____ / 20_____ school year:

- I give permission for my child to receive prescribed medication at school as prescribed by my child's physician or nurse practitioner
- I will assure that the needed medication will be handed to the school nurse by an adult in its original prescription labeled container
- I give permission for my child to have a designated delegate who has been trained by the school nurse to assist my child with a pre-filled auto-injector mechanism containing epinephrine. This assistance will only be needed if my child should experience an allergic / anaphylactic reaction in school or at a school sponsored event and if the school nurse is not present.
- I understand that the Metuchen School District and its employees or agents shall incur no liability as a result of any injury arising from the administration of medication and we, the parents or guardians, indemnify and hold harmless the Metuchen School District and its employees or agents against any claims arising out of the such administration. Any person who acts in good faith in accordance with the requirement of P.L. 2007,c57 shall be immune from any civil or criminal liability arising from actions performed pursuant to that action.

I will contact the school nurse with any questions or changes in my child's health status.

_____ _____
Print name of Parent / guardian Signature of Parent / guardian

_____
Date