Leaders of Tomorrow 2
Preschool
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IMPORTANT MEDICAL DOCUMENTS:
MUST BE COMPLETED BY PHYSICIAN & PARENT/GUARDIAN
PRIOR TO SCHOOL COMMENCEMENT

This packet includes:

- Consent for Emergency Medical Treatment
- Universal Child Health Record
- Asthma Action Plan
- Food Allergy Action Plan
- Seizure Action Plan
- Health History Questionnaire

Leaders of Tomorrow 2
Preschool

CONSENT FOR CHILD'S EMERGENCY MEDICAL TREATMENT & TRANSPORT

I, _____, hereby give my consent for emergency medical

treatment of my son/daughter _____ to any duly licensed medical doctor, while under the care of Leaders of Tomorrow Preschool. This medical care may include physical examinations and any necessary tests, which in the opinion of the physician are deemed necessary and/or advisable. This does not include the right to perform surgical operations without any further consent, except in the case of an emergency when an effort has been made to locate me.

IN THE EVENT THAT AN EMERGENCY OCCURS, I AUTHORIZE LEADERS OF TOMORROW PRESCHOOL TO SEEK EMERGENY MEDICAL CARE FOR MY CHILD AS DEEMED NECESSARY BY THE DIRECTOR AND/OR TRANSPORT MY CHILD TO BAYONNE HOSPITAL BY AMBULANCE.

Child's Name:_____

Mother/Guardian
Signature: _____

Home Address: _____

Home Number: _____ Work Number: _____

Cell Number: _____

Father/Guardian
Signature: _____

Home Address: _____

Home Number: _____ Work Number: _____

Cell Number: _____

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

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

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	

Distribution: Original-Child Care Provider Copy-Parent/Guardian Copy-Health Care Provider

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

(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 ________

[illegible]

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.

Disclaimers: [illegible]

[illegible]

REVISED MAY 2017

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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.

FARE FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

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

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) 5/2018

EPILEPSY FOUNDATION · epilepsy therapy project
STRONGER TOGETHER

Seizure Action Plan

Effective Date

This student is being treated for a seizure disorder. The information below should assist you if a seizure occurs during school hours.

Student's Name _____ Date of Birth _____

Parent/Guardian _____ Phone _____ Cell _____

Other Emergency Contact _____ Phone _____ Cell _____

Treating Physician _____ Phone _____

Significant Medical History _____

Seizure Information

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs:

Student's response after a seizure:

Basic First Aid Care Instruction

Please describe basic first aid procedures:

Does student need to leave the classroom after a seizure? ☐ Yes ☐ No
If YES, describe process for returning student to classroom:

Basic Seizure First Aid

- Stay calm & track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Record seizure in log

For tonic-clonic seizure:

- Protect head
- Keep airway open/watch breathing
- Turn child on side

A seizure is generally considered an emergency when:

- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has distress
- Student has a first time seizure
- Student has breathing difficulties
- Student has a seizure in water

Emergency Response

A "seizure emergency" for this student is defined as:

Seizure Emergency Protocol
(Check all that apply and clarify below)

- ☐ Contact school nurse at _____
- ☐ Call 911 for transport to _____
- ☐ Notify parent or emergency contact
- ☐ Administer emergency medications as indicated below
- ☐ Notify doctor
- ☐ Other _____

Treatment Protocol During School Hours (include daily and emergency medications)

Emerg. Med. ✓	Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Does student have a **Vagus Nerve Stimulator?** ☐ Yes ☐ No If YES, describe magnet use:

Special Considerations and Precautions (regarding school activities, sports, trips, etc.)

Describe any special considerations or precautions:

Physician Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____

Leaders of Tomorrow 2
Preschool

HEALTH HISTORY QUESTIONNAIRE

Student's Name _____ Date of Birth _____

Parents/Guardian _____ Daytime Phone Number _____

Child's Doctor _____ Cell/Emergency Number _____

Developmental Milestones (age at which the child)
Sat up _____ Crawled _____ Walked _____ Talked _____ Toilet Trained _____

Health Problems
Has your child ever had any of the following?

	Yes	No	Age		Yes	No	Age
Heart Disease	___	___	___	Seizure/Convulsion	___	___	___
Fainting	___	___	___	Diabetics	___	___	___
Kidney Disease	___	___	___	Ear Infections	___	___	___
Sickle Cell	___	___	___	Lead Poisoning	___	___	___
Hearing Problem	___	___	___	Learning Problem	___	___	___
Vision Problem	___	___	___	Broken Bones	___	___	___
Surgery	___	___	___	Asthma	___	___	___

Explain any "yes" answers and list any other health problems.
_____
_____
_____

Activity restrictions specified by MD (note required) _____

Hospitalizations
Has your child ever been hospitalized for any reason? Yes ____ No ____
Reason for hospitalization _____ How many days _____ Years _____
Reason for hospitalization _____ How many days _____ Years _____

Asthma
Has your child ever had asthma? Yes ____ No ____
How often does your child have asthma attacks? _____
What triggers your child's asthma? _____
Has your child used asthma medicine in the past 2 years? Yes ____ No ____
If yes, please indicate medicine used _____

Allergies

To food? Yes ____ No ____ To medicine? Yes ____ No ____

If yes, please list things child is allergic to and indicate symptoms:

_____

_____

Anaphylaxis? Yes ____ No ____ Epipen? Yes ____ No ____

Medications

Does your child take any prescription medicine at home? Yes ____ No ____

If yes, please list medicine (s) _____

_____

Will your child be taking prescription medicine at school? Yes ____ No ____

If yes, please list medicine(s) _____

_____

Parents/Guardian Signature: _____ Date _____

I GIVE PERMISSION TO SHARE THIS INFORMATION WITH STAFF MEMBERS INVOLVED IN MY CHILD'S CARE AND EDUCATION.

Parents/Guardian Signature: _____ Date _____

Reviewed by: _____ Date _____