FROM THE DESK OF THE SCHOOL NURSE
School Year 2022-2023

Dear Parents,

Your child's health and well being is a priority that the Cheder takes very seriously. Please read this letter carefully, complete the forms and submit to the school office. As parents often require copies of these forms for camp, etc., please keep necessary copies for your records.

Please note: According to state regulations, no child may enter the classroom until the school has received a copy of the child's immunization history and physical exam form.

IMMUNIZATIONS

The New Jersey State Department of Health requires that all children attending school must have a complete record of immunizations on file.

Please note: Clifton Cheder and Bais Yaakov of Clifton only accept children who are fully vaccinated. We do not accept religious exemptions in place of vaccinations.

The State of New Jersey can issue a costly fine for each immunization record that is not received. All missing immunizations must be completed in a timely manner. Check with your pediatrician to make sure that your child's immunizations are up to date. Any time any of your school age children receive a vaccination, please send in documentation from your doctor to the school so we can update your child's file as per NJ Health Department regulations.

STUDENTS UP TO THE AGE OF 5: In 2008, the New Jersey Health Department mandated an annual influenza ("flu") vaccination for children attending preschool (6-59 months of age) by December 31st of each year. **Records are required to be submitted by December 1, 2022**.

KINDERGARTEN: Students are required to have additional immunizations when they reach 4 and 5 years of age.

6th GRADE: Students are required to have additional immunizations of Tdap and Meningococcal when they reach 11 years of age/6th grade.

PHYSICAL EXAMS

Physical exams are mandated for: **all new students, Kindergarten, Pre1A** and **6th grade** students. The enclosed "*Universal Child Health Record"* is the preferred form; however, any physical that was completed in this calendar year is acceptable to fulfill this requirement.

Parents are advised to bring all their children for a yearly physical for the optimal development, although not required by law.

MEDICATION

Enclosed is a medication consent form, *"Authorization to Administer Medications/Remedies to Students,"* for you and your physician to fill out authorizing the administration of medication that may need to be given during school hours. This includes over the counter remedies.

Should your child need antibiotics/medication for any given period of time, a doctor's note must accompany the medication with the diagnoses, exact dose, time, route of administration and duration of treatment. In addition, parental consent must be given in writing.

MEDICAL CONDITION AND/OR ALLERGIES

If your child has a medical condition that we should be aware of, such as asthma, diabetes, severe food allergies, or any other condition that might cause an emergency during school hours, kindly have your physician fill out the attached relevant forms: *"Allergy Treatment Plan," "Asthma Treatment Plan," "Special Medical Needs Form,"* and/or *"Request for Self Administration of Medication."*

Students who have a nut, sesame, or any other allergy for which an Epi-pen is needed, **must bring two Epi-pens to be stored in school**. Your compliance with this will enable you to receive your admission card.

Medication will not be administered to any student without the proper authorization from the child's physician and parent. All medication orders ***must be renewed yearly.*** All medication and supplies must be brought to the school office. Please check the expiration dates on the medications that you send and replace them as needed if they expire.

Documents can be sent to the main office at secretary@cliftoncheder.org, or faxed to 866-518-5682. Confidential communication can be emailed to chedernurse@cliftoncheder.org.

Thank you.

Fondly,

Esti Meth R.N.

Mrs. Esti Meth, RN
School Nurse

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.

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AUTHORIZATION TO ADMINISTER MEDICATIONS/REMEDIES TO STUDENTS

School Year 2022-2023

One per Child

(please make/request additional copies as needed)

Last Name: _____ First Name: _____

Grade: _____ D.O.B. _____

I hereby authorize Clifton Cheder nurses, principals, or their designees to administer the following medication/remedies to my child.

Name of Medication or generic equivalent	Route	Dosage	Schedule	Mark a ✓ if you want to be contacted prior to administration	Mark an X if med is <u>not to be given</u>
Tylenol	PO	Per labels instruction by age/weight	Every 4-5 hrs. as needed for discomfort or elevated temp		
Advil	PO	Per labels instruction by age/weight	Every 6 hrs. as needed for discomfort or elevated temp		
Benadryl	PO	Per labels instruction by age/weight	Every 6 hrs. as needed for discomfort of allergic reaction		
Chewable Anti-Acid (Tums)	PO	5-11 years: one tablet 12 yrs.+: two tablets	Every 6 hrs. as needed		
Anti-Itch Lotion (Calamine)	Topical	As needed	As needed		
First Aid Antibiotic Ointment (i.e. Bacitracin)	Topical	As needed	As needed		

_____ _____
Parent/Guardian Name (printed) Parent/Guardian Signature

_____ _____
Physician Name (printed) Physician Signature

Please note that NJ State Law requires that MD and parent sign this annually.

Where Chinuch and Cheshek go hand in hand

1333 BROAD STREET ❖ CLIFTON, NJ 07013 ❖ 973-472-0011 ❖ ADMIN@CLIFTONCHEDER.ORG ❖ FAX: 866-518-5682

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ALLERGY TREATMENT PLAN

Last Name: _____

First Name: _____

Grade: _____ D.O.B. _____

Asthmatic: ☐ Yes* ☐ No * Higher risk for severe reaction; please fill out *Asthma Treatment Plan*

ALLERGIC TO:	If exposed to allergen and there are NO symptoms or mild localized symptoms:	If anaphylactic symptoms are shown*
	☐ Epi-pen ☐ Epi-pen Jr ☐ Antihistamine Medication: Dose: Route:	EPIPEN / EPIPEN JR
	☐ Epi-pen ☐ Epi-pen Jr ☐ Antihistamine Medication: Dose: Route:	EPIPEN / EPIPEN JR

Note: Nut and sesame allergies can have severe reactions and will be treated with an Epi-pen even if no symptoms are shown.

* Anaphylactic symptoms: Itching, tingling, or swelling of lips, tongue, mouth; hives, itchy rash, swelling of the face or extremities; nausea, abdominal cramps, vomiting, diarrhea; tightening of throat, hoarseness, hacking cough; shortness of breath, repetitive coughing, wheezing; thready pulse, low blood pressure, fainting, pale, blueness

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, AUTHORIZATION IS GIVEN TO MEDICATE OR TO TAKE CHILD TO MEDICAL FACILITY!

_____ _____
Parent/Guardian Signature Date

_____ _____
Physician's Signature Date

- -

Students who have an allergy for which an Epi-pen is needed must have two clearly labeled Epi-pens stored in the school. Please check the expirations dates of all medication given in.

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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"
PACNJ approved Plan available at www.pacnj.org

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.

Disclaimers: The use of this Website/PACNJ Asthma Treatment Plan and its content is at your own risk. The content is provided on an "as is" basis. The American Lung Association of the Mid-Atlantic (ALAM-A), the Pediatric/Adult Asthma Coalition of New Jersey and all affiliates disclaim all warranties, express or implied, statutory or otherwise, including but not limited to the implied warranties or merchantability, non-infringement of third parties' rights, and fitness for a particular purpose. ALAM-A makes no representations or warranties about the accuracy, reliability, completeness, currency, or timeliness of the content. ALAM-A makes no warranty, representation or guaranty that the information will be uninterrupted or error free or that any defects can be corrected. In no event shall ALAM-A be liable for any damages (including, without limitation, incidental and consequential damages, personal injury/wrongful death, lost profits, or damages resulting from data or business interruption) resulting from the use or inability to use the content of this Asthma Treatment Plan whether based on warranty, contract, tort or any other legal theory, and whether or not ALAM-A is advised of the possibility of such damages. ALAM-A and its affiliates are not liable for any claim, whatsoever, caused by your use or misuse of the Asthma Treatment Plan, nor of this website.

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 AUGUST 2014

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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.

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

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CHEDER BAIS YAAKOV of CLIFTON
...where chinuch & cheshek go hand in hand

SPECIAL MEDICAL NEEDS FORM
(ADD, Seizures, Diabetic etc.)

(For allergies, please fill out Allergy Treatment Plan only. For Asthma, please also fill out Asthma Treatment Plan)

Last Name: _____ First Name: _____

Grade: _____ D.O.B. _____

Physician Student sees for this condition: _____ Phone: _____

Other Physician: _____ Phone: _____

MEDICAL SITUATION
Diagnosis:
Brief description of how this condition can affect your child and how we can be of assistance:
Activity Restrictions:
Currently taking Medication: ☐ Yes ☐ No Medication Regimen (including medication not usually given in school):

If your child may need medication, please fill out the section below. Please ensure that the office has an updated (and not expired) supply of all the medication/equipment **DUE AT TIME OF ADMISSIONS**. If the child will be administering the medication himself, please fill out *Request for Self-Administration of Medication Form*.

AUTHORIZATION TO ADMINISTER MEDICATION IN SCHOOL		
Symptoms that require medication:		
Medication:	Dose:	How often:
	Purpose of Drug:	Possible Side Effects:
Medication:	Dose:	How often:
	Purpose of Drug:	Possible Side Effects:

_____ _____
Parent/Guardian Signature Date

_____ _____
Physician's Signature Date

Where Chinuch and Cheshek go hand in hand

1333 BROAD STREET ❖ CLIFTON, NJ 07013 ❖ 973-472-0011 ❖ ADMIN@CLIFTONCHEDER.ORG ❖ FAX: 866-518-5682

CHEDER BAIS YAAKOV of CLIFTON
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REQUEST FOR SELF ADMINISTRATION OF MEDICATION

Last Name: _____

First Name: _____

Grade: _____ D.O.B. _____

Asthma Inhalers _____ Insect Sting Kit _____

To Be Completed By Physician: (Please Print)
I am requesting that the above-named student be allowed to self-administer the following medications:

Name of medication: _____

Diagnosis for which medication is given: _____

Prescribed dosage and time to be taken: _____

If daily, at what time: _____

If "when needed," describe indications: _____

How soon can it be repeated: _____

Possible side effects and/or special precautions to be taken: _____

_____

Length of time this medication is prescribed: _____

Conditions under which self-administration will take place:

☐ Independently. Child has been trained and is proficient in self-administrating

☐ Under the supervision of school nurse/school staff

Medication should be: ☐ Stored in the nurse's office or designated area

☐ In the possession of student

_____ _____
Physician's Name (print) Physician's Signature

_____ _____
Telephone Number Date

To be completed by parent: I give permission for my child to self-administer the medication described above. I will notify the school nurse if this medication is no longer required or self-administration is no longer directed by the physician.

The medication is to be provided by me in the original labeled container. To my knowledge my child is not allergic to this medication.

I hereby release and hold harmless the Board, its agents, servants, and employees from any and all liability for injuries or other damage which may result to the student, his/her servants and representatives which may result from administration of the medication.

_____ _____
Parent/Guardian Signature Date