



Mrs. Susan Dworken
JKHA Head of School

Mr. Michael Grad
Executive Director

Rabbi Eliezer E. Rubin
Klatt Family Rosh HaYeshiva
MS and HS Principal



Dear Parents:

Attached please find an updated packet with student health forms for the **Sept. 2010 – June 2011** school year. This information is required by the school annually. The forms submitted from last year will not be valid. Please observe the signature requirements where specified.

Forms required for all students:

- ❖ Authorization for Release of Information (parent signature required)
- ❖ Student Medical Information (parent signature required)
- ❖ Annual Health Exam - Exam must be between **Sept. 1, 2009 and Sept. 1, 2010** (physician signature required)
- ❖ Medication Consent – over-the-counter medications will NOT be given out unless this form is current with BOTH physician and parent signatures

Forms required for any student with specific medical needs: (parent and physician signatures required)

- ❖ Self-Administered Medication Permission Form – required for all students who carry inhalers or Epipens, or any other self-administered medications
- ❖ Food Allergy Action Plan – required for all students who have a documented food or other type of severe allergy
- ❖ Asthma Action Plan – required for all students with a diagnosis of asthma

Form required for middle school and high school students participating in after- school sports:

- ❖ Sports Participation Form (physician signature required)

Please refer to the website (www.jkha.org) for copies of these forms and detailed information.

We strongly suggest that you make copies of your completed forms for your records.

ALL Forms MUST be returned before school begins in September 2010.

Thank you for your timely response, and have a healthy and safe school year.

Barbara Zohar, RN BA
JKHA/JKHAMS
School Nurse
973-597-1115 x1118
Fax: 973-488-0218

Rona Dickman, RN BSN
RKYHS
School Nurse
973-597-1115 x1282
Fax: 973-488-0219

110 South Orange Avenue • Livingston, NJ 07039 • Phone: 973.597.1115 • Fax: 973.597.3362
Elementary Email: JKHA-Info@jkha.org • High School Email: RKYHS-Info@rkyhs.org
JKHA Website: www.jkha.org • RKYHS Website: www.rkyhs.org

**Joseph Kushner Hebrew Academy/Rae Kushner
Yeshiva High School**

STUDENT'S NAME _____ GRADE _____

**AUTHORIZATION FOR RELEASE OF INFORMATION
2010-2011**

To all JKHA/RKYHS Parents:

This form will be used to authorize the release of any pertinent medical information regarding your child to appropriate professional staff involved in the care of your child. Please complete, sign, and return the form below. It will be in effect for the **2010 - 2011** school year only.

As Parent/Guardian of the above named student, I hereby authorize the release of pertinent information such as medical conditions, allergies, medical protocols, and medication regimes, to be exchanged among appropriate professional staff involved in the care of the above-mentioned student. This consent is valid for the **2010-2011** school year, and is intended to allow the staff at JKHA/RKYHS to better serve my child.

Name of Parent/Guardian (print) _____

Signature _____

Date _____

Place child's photo here

Joseph Kushner Hebrew Academy/Rae Kushner Yeshiva High School

STUDENT'S NAME _____ GRADE _____

Student Medical Information 2010-2011

Parent/Guardian please complete:

Is your child currently diagnosed with any medical condition that requires medication or treatment that the nursing staff should be aware of? yes no

Diagnosis _____
Medication _____
Treatment _____

Is your child allergic to any medications, foods, other (i.e. bee stings)?
(If yes, please complete the Food Allergy Action Plan) yes no

Allergen	Reaction	Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does your child have a prescription for an Epipen/Epipen Jr.? yes no

Has your child ever had an allergic reaction that required epinephrine? yes no

Does your child carry an inhaler? yes no

(If your child carries an Epipen or inhaler, please complete the Self-Administered Medication Permission Form)

In Case of Emergency:

Insurance Company or Health Plan: _____
ID# or Medical record# _____
Group# _____

If emergency treatment is required, I authorize the school to make the necessary arrangements to assist in the well-being of my child, including calling 911 and transporting my child to the nearest hospital.

Parent/Guardian Name (please print) _____

Signature _____ Date _____

JKHA / JKHAMHS / RKYHS / SINAI

ANNUAL HEALTH EXAM FORM 2010 – 2011

Phone: 973-597-1115 Ext. 1118 (HS x1282)

Fax: 973-488-0218 (HS x0219)

Name: _____ DOB: _____ Age: ____ Sex: ____ Grade: ____

Address: _____ Phone#: _____

Are you a NEW student at Kushner? YES ____ NO ____ LAST SCHOOL ATTENDED _____

Immunizations (M/D/Y) full date required

VACCINE	#1	#2	#3	#4	#5	#6	REQUIREMENTS
DTP/TDAP							1 DTP after 4 th Birthday/ Tdap entering grade 6 (born after 1997)
POLIO							1 Polio After 4 th Birthday
MMR							2 nd MMR Prior to Entering K
HEP B							Hep B 3 dose series K-12
HIB							1 dose Hib after 1 st birthday for child under five
MANTOUX							PPD (Tx required if reaction over 10mm)
VARIVAX							Or date of actual chicken pox: / /
PCV							1 dose on/after 1 st birthday for child under five
MENINGOCOCCAL							1 dose entering grade 6 (born after 1997)
INFLUENZA							1 dose annually between Sept. 1 & Dec. 31 age 5↓
OTHER							

***Annual MD Exam**

	Normal	Abnormal Findings
Heart		
Lungs		
EENT		
Abdomen		
Skin		
Nervous System		
Blood		
Genito-Urinary		
Nutrition		
Orthopedic		
Other		

Ht: _____	Wt: _____	BP: _____
Visual Acuity:	R: ____ /20	L: ____ /20
With Glasses:	Yes ____	No ____
Hearing:	_____	_____
	R-dB	L-dB
Scoliosis Check: Date: _____	Mandatory in grades 5, 7, 9, 11	
Results: _____		
*Past Surgery / Hospitalization _____		
*CAN PARTICIPATE IN ALL SPORTS: Yes ____ *No ____		

*Comments: _____

Allergies/Medications

- ❖ NJ State law requires a separate medication consent form for each medication administered in school. It must be filled out and signed by **BOTH Parent and Doctor. NO EXCEPTIONS / NO PHONE PERMISSION**

Allergies: _____

RX Medications: time and dose _____

Inhalers / Nebulizer: Yes ____ No ____ Epi-Pen: Yes ____ No ____

- ❖ List any medical concerns that the nursing staff should be aware of? _____

Date of Exam

Signature of Physician

MD Stamp (below)

JKHA/JKHAMS/RKYHS // SINAI
ANNUAL MEDICATION CONSENT FORM 2010-2011

NJ State Law requires that a **medication consent form** for each medication is to be completed and signed by **parent & doctor** in order to be administered in school. **NO EXCEPTIONS AND NO PHONE PERMISSION.** Permission to administer meds will remain in effect for the current school year only. (September 2010 - June 2011)

NAME OF STUDENT _____ GRADE _____ D.O.B./AGE _____

SECTION 1 DAILY MEDICATION: Prescription medication to be given by the nurse

Medication #1 _____ Dosage _____ Time _____
 Side effects _____ *Also give if Friday or early dismissal day? (circle) Yes / No

Medication #2 _____ Dosage _____ Time _____
 Side effects _____ *Also give if Friday or early dismissal day? (circle) Yes / No

SECTION 2 AS NEEDED MEDICATION: Over-the-counter medication stocked at school

CHECK HERE IF YOU DO NOT WANT YOUR CHILD TO RECEIVE ANY MEDICATION AT SCHOOL

PLEASE CIRCLE YES OR NO

- | | | | |
|-----|----|---------------------------------|---|
| Yes | No | <u>Acetaminophen</u> | 325mg for pain or fever
1 or 2 tablets 6 to 12 years; liquid per age/wt.
May be repeated in 4 hours as needed |
| Yes | No | <u>Ibuprofen</u> | 200mg for pain or menstrual cramps
1 to 2 tablets / liquid per age/weight
May repeat 4 to 6 hours as needed |
| Yes | No | <u>Benadryl</u> | 25mg-50mg for acute allergic reactions <u>ONLY</u> 1-2 tabs/1-2 tsp liquid |
| Yes | No | <u>Tums/Pepto Bismol</u> | 1-2 tablets as needed for indigestion (for children in third grade and above) |
| Yes | No | <u>Midol</u> | <u>FOR MIDDLE SCHOOL AND HIGH SCHOOL STUDENTS ONLY.</u> As directed for menstrual cramps |
| Yes | No | <u>Aleve</u> | <u>FOR MIDDLE SCHOOL AND HIGH SCHOOL STUDENTS ONLY.</u> As directed for muscle discomfort |

The above medications will be administered for the entire school year (Sept. 2010 – June 2011) unless otherwise indicated by your MD. I authorize the school nurse to administer the above medication(s). **BOTH SIGNATURES ARE REQUIRED****

 PHYSICIAN'S SIGNATURE**

 DATE

MD STAMP (BELOW)

 PARENT'S SIGNATURE**

 DATE

Joseph Kushner Hebrew Academy/Rae Kushner Yeshiva High School

Self-Administered Medication Permission Form

A pupil may be permitted to self-administer medication under the following conditions:

- The child's physician must certify, in writing, that the child has asthma, diabetes or any life threatening illness and that the child is capable of and has been instructed in the proper administration of the required medication.
- The parent must understand that JKHA/RKYHS will not accept any responsibility for an injury arising from self-medication and sign the following statement.
- The medication must be in the original prescription container, properly labeled with the student's name.

Permission is effective for the school year for which it is granted and must be renewed annually.

To be completed by physician:

Student Name: _____

Grade: _____ Date of Birth: _____

Diagnosis: _____

Name of medication: _____ Dosage: _____

Patient/Student is capable and has been instructed in the proper self-medication of his/her medication:

yes no

Physician's Signature: _____ Date: _____

Physician's Name (please print): _____

Parent/guardian signature required:

I hereby give permission for my child to self-administer medication as prescribed by his/her physician. I accept full responsibility for my child's self-medication and will not hold JKHA/RKYHS responsible for any injury arising from self-medication.

Signature _____ Date _____

Home phone _____ Business phone _____

**Self-Administration of Medications by Pupils
for Asthma or other Potentially Life Threatening Illnesses**

AN ACT concerning the self-administration of medication by school pupils for asthma, amending P.L.1993, c.308 and supplementing chapter 40 of Title 18A of the New Jersey Statutes, and making an appropriation.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. Section 1 of P.L.1993, c.308 (C.18A:40-12.3) is amended to read as follows:

C.18A:40-12.3 Self-administration of medication by pupil permitted.

1. a. A board of education or the governing board or chief school administrator of a nonpublic school shall permit the self-administration of medication by a pupil for asthma or other potentially life-threatening illnesses provided that:

(1) the parents or guardians of the pupil provide to the board of education or the governing board or chief school administrator of a nonpublic school written authorization for the self-administration of medication;

(2) the parents or guardians of the pupil provide to the board of education or the governing board or chief school administrator of a nonpublic school written certification from the physician of the pupil that the pupil has asthma or another potentially life-threatening illness and is capable of, and has been instructed in, the proper method of self-administration of medication;

(3) the board of education or the governing board or chief school administrator of a nonpublic school informs the parents or guardians of the pupil in writing that the district and its employees or agents or the nonpublic school and its employees or agents shall incur no liability as a result of any injury arising from the self-administration of medication by the pupil;

(4) the parents or guardians of the pupil sign a statement acknowledging that the district or the nonpublic school shall incur no liability as a result of any injury arising from the self-administration of medication by the pupil and that the parents or guardians shall indemnify and hold harmless the district and its employees or agents or the nonpublic school and its employees or agents against any claims arising out of the self-administration of medication by the pupil; and

(5) the permission is effective for the school year for which it is granted and is renewed for each subsequent school year upon fulfillment of the requirements in paragraphs (1) through (4) of this subsection.

b. Notwithstanding any other law or regulation to the contrary, a pupil who is permitted to self-administer medication under the provisions of this section shall be permitted to carry an inhaler at all times, provided that the pupil does not endanger himself or other persons through misuse.

c. Any person who acts in good faith in accordance with the requirements of this act shall be immune from any civil or criminal liability arising from actions performed pursuant to this act.

Food Allergy Action Plan

Student's Name: _____ D.O.B: _____ Teacher: _____



ALLERGY TO: _____

Asthmatic Yes* No *Higher risk for severe reaction

◆ STEP 1: TREATMENT ◆

<u>Symptoms:</u>	<u>Give Checked Medication**:</u> <small>** (To be determined by physician authorizing treatment)</small>
▪ If a food allergen has been ingested, but <i>no symptoms</i> :	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
▪ Mouth Itching, tingling, or swelling of lips, tongue, mouth	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
▪ Skin Hives, itchy rash, swelling of the face or extremities	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
▪ Gut Nausea, abdominal cramps, vomiting, diarrhea	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
▪ Throat† Tightening of throat, hoarseness, hacking cough	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
▪ Lung† Shortness of breath, repetitive coughing, wheezing	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
▪ Heart† Weak or thready pulse, low blood pressure, fainting, pale, blueness	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
▪ Other† _____	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
▪ If reaction is progressing (several of the above areas affected), give:	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine

†Potentially life-threatening. The severity of symptoms can quickly change.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15 mg (see reverse side for instructions)

Antihistamine: give _____
medication/dose/route

Other: give _____
medication/dose/route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

◆ STEP 2: EMERGENCY CALLS ◆

1. Call 911 (or Rescue Squad: _____). State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. _____ Phone Number: _____

3. Parent _____ Phone Number(s) _____

4. Emergency contacts:
Name/Relationship _____ Phone Number(s) _____

a. _____ 1.) _____ 2.) _____

b. _____ 1.) _____ 2.) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian's Signature _____ Date _____

Doctor's Signature _____ Date _____

(Required)

TRAINED STAFF MEMBERS

1. _____

Room _____

2. _____

Room _____

3. _____

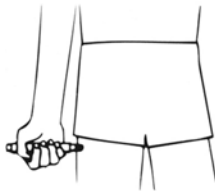
Room _____

EpiPen® and EpiPen® Jr. Directions

- Pull off gray activation cap.



- Hold black tip near outer thigh (always apply to thigh).



- Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.

Twinject® 0.3 mg and Twinject® 0.15 mg Directions



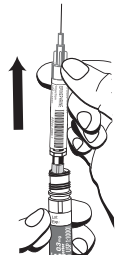
- Remove caps labeled "1" and "2."
- Place rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.



SECOND DOSE ADMINISTRATION:

If symptoms don't improve after 10 minutes, administer second dose:

- Unscrew rounded tip. Pull syringe from barrel by holding blue collar at needle base.
- Slide yellow collar off plunger.
- Put needle into thigh through skin, push plunger down all the way, and remove.



Once EpiPen® or Twinject® is used, call the Rescue Squad. Take the used unit with you to the Emergency Room. Plan to stay for observation at the Emergency Room for at least 4 hours.

For children with multiple food allergies, consider providing separate Action Plans for different foods.

***Medication checklist adapted from the Authorization of Emergency Treatment form developed by the Mount Sinai School of Medicine. Used with permission.*



Asthma Treatment Plan Patient/Parent Instructions



The **PACNJ Asthma Treatment Plan** is designed to help everyone understand the steps necessary for the individual patient to achieve the goal of controlled asthma.

1. Patients/Parents/Guardians: Before taking this form to your Health Care Provider:

Complete the top left section with:

- Patient's name
- Patient's date of birth
- Patient's doctor's name & phone number
- Parent/Guardian's name & phone number
- An Emergency Contact person'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 circle 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 you or your child to follow

3. Patients/Parents/Guardians & Health Care Providers together:

Discuss and then complete the following areas:

- Patient's peak flow range in the Healthy, Caution and Emergency sections on the left side of the form
- Patient's asthma triggers on the right side of the form
- For Minors Only 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

This Asthma Treatment Plan is meant to assist, not replace, the clinical decision-making required to meet individual patient needs. Not all asthma medications are listed and the generic names are not listed.

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.

Asthma Treatment Plan

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



"Your Pathway to Asthma Control"
Original PACNJ approved Plan available at
www.pacnj.org



(Please Print)

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

HEALTHY



You have all of these:

- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work, exercise, and play

And/or Peak flow above _____

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

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
<input type="checkbox"/> Advair® <input type="checkbox"/> 100, <input type="checkbox"/> 250, <input type="checkbox"/> 500	.....1 inhalation twice a day
<input type="checkbox"/> Advair® HFA <input type="checkbox"/> 45, <input type="checkbox"/> 115, <input type="checkbox"/> 230	.....2 puffs MDI twice a day
<input type="checkbox"/> Asmanex® Twisthaler® <input type="checkbox"/> 110, <input type="checkbox"/> 220 <input type="checkbox"/> 1, <input type="checkbox"/> 2 inhalations a day
<input type="checkbox"/> Flovent® <input type="checkbox"/> 44, <input type="checkbox"/> 110, <input type="checkbox"/> 220	.....2 inhalations twice a day
<input type="checkbox"/> Flovent® Diskus® 50 mcg	.....1 inhalation twice a day
<input type="checkbox"/> Pulmicort Flexhaler® <input type="checkbox"/> 90, <input type="checkbox"/> 180 <input type="checkbox"/> 1, <input type="checkbox"/> 2 inhalations <input type="checkbox"/> once or <input type="checkbox"/> twice a day
<input type="checkbox"/> Pulmicort Respules® <input type="checkbox"/> 0.25, <input type="checkbox"/> 0.5, <input type="checkbox"/> 1.0	..1 unit nebulized <input type="checkbox"/> once or <input type="checkbox"/> twice a day
<input type="checkbox"/> Qvar® <input type="checkbox"/> 40, <input type="checkbox"/> 80	.....2 inhalations twice a day
<input type="checkbox"/> Singulair® <input type="checkbox"/> 4, <input type="checkbox"/> 5, <input type="checkbox"/> 10 mg	.....1 tablet daily
<input type="checkbox"/> Symbicort® <input type="checkbox"/> 80, <input type="checkbox"/> 160	.....2 puffs MDI twice a day
<input type="checkbox"/> Other	
<input type="checkbox"/> None	

Remember to rinse your mouth after taking inhaled medicine.

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

Triggers

Check all items that trigger patient's asthma:

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

Other:

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

CAUTION



You have any of these:

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

And/or Peak flow from _____ to _____

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

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

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

EMERGENCY



Your asthma is getting worse fast:

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

And/or Peak flow below _____

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

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

The Pediatric/Adult Asthma Coalition of New Jersey, sponsored by the American Lung Association of New Jersey, and this publication are supported by a grant from the New Jersey Department of Health and Senior Services (NJDHSS), with funds provided by the U.S. Centers for Disease Control and Prevention (USCDCP) under Cooperative Agreement 5U59EH000206-2. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the NJDHSS or the USCDCP.

Although this document has been funded wholly or in part by the United States Environmental Protection Agency under Agreements XA9264401-4 and XA9726707-1 to the American Lung Association of 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.

EFFECTIVE MARCH 2008
Permission to reproduce blank form
Approved by the New Jersey Thoracic Society

FOR MINORS ONLY:

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

PHYSICIAN/APN/PA SIGNATURE _____ DATE _____

PARENT/GUARDIAN SIGNATURE _____

PHYSICIAN STAMP

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

Joseph Kushner Hebrew Academy/Rae Kushner Yeshiva High School

Sports Participation Form

Required for middle school and high school students participating in after-school sports.
Student must have a **current health exam form** in addition to the sports participation form.

STUDENT'S NAME _____ **GRADE** _____

NOTES TO THE EXAMINING PROVIDER

Conditions requiring clearance before sports participation include, but are not limited to the following:

Anaphylaxis; Atlantoaxial instability; Bleeding disorder; Hypertension; Congenital heart disease; Dysrhythmia; Mitral valve prolapse; Heart murmur; Cerebral palsy; Diabetes mellitus; Eating disorders; Heat illness history; One-kidney athletes; Hepatomegaly, Splenomegaly; Malignancy; Seizure Disorder; Marfan Syndrome; History of repeated concussion; Organ transplant recipient; Cystic fibrosis; Sickle cell disease; and/or One-eyed athletes or athletes with vision greater than 20/40 in one eye.

SAMPLES OF CLASSIFICATION OF SPORTS BY CONTACT

Contact/Collision	Limited Contact	Non-Contact	
		Strenuous	Non-strenuous
Basketball	Baseball	Discus	Bowling
Diving	Cheerleading	Javelin	Golf
Field Hockey	Fencing	Shot put	
Football	High Jump	Rowing	
Ice Hockey	Pole vault	Running/Cross Country	
Lacrosse	Gymnastics	Strength Training	
Soccer	Skiing	Swimming	
Wrestling	Softball	Tennis	
	Volleyball	Track	

CLEARANCES: (See notes for conditions requiring attention and for a list of sports by level of contact)

- A. Student is cleared for participation in **all** sports without restriction.
- B. Student is **withheld clearance** for participation in any sport until evaluation / treatment of:

- C. Student is cleared for participation in **limited types** of sports which **exclude** the following types of sports contact: (CHECK ALL THAT APPLY)

<input type="checkbox"/> CONTACT/COLLISION	<input type="checkbox"/> NON-CONTACT/STRENUOUS
<input type="checkbox"/> LIMITED CONTACT	<input type="checkbox"/> NON-CONTACT/NON-STRENUOUS

Due to: _____

STUDENT EXAMINED BY:

Primary Care Provider
School Physician Provider
License Type: MD/DO
APN
PA

Physician's/Provider's Stamp:

PHYSICIAN'S/PROVIDER'S SIGNATURE: _____ Today's Date: _____
Date of Exam: _____