

## REQUEST FOR HEALTH RECORDS

Student Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Dear Parent/Guardian,

In this health packet you will find forms that need to be updated for the upcoming school year. These forms are to be **completed and signed by the child's doctor** and sent to the school.

- Universal Child Health Record:** physical examination performed **within the past year**.
- Medication Administration in School Permission Form:** If your child needs to receive medication during school hours, this form must be completed by the parent and doctor and returned to the school.
- FARE Allergy Action Plan:** If your child has any allergies this form must be completed by the doctor.
- Asthma Action Plan:** If your child has asthma, this form must be completed by the doctor.
- Seizure Action Plan:** If your child has seizures, this form must be completed by the doctor.

If your child **does not** have allergies, asthma, seizures, or **does not** need medication administered at school the associated allergy, asthma, seizure and medication forms **do not** have to be completed.

The New Jersey State Law (N.J.A.C. 8:57-4) requires the following immunizations be provided:

- DTaP:** 4 (four) doses with one dose after the 4th birthday, or any 5 (five) doses.
- IPV (Polio):** 3 (three) doses with one dose after the 4th birthday, or any 4 (four) doses.
- MMR (Measles, mumps, rubella):** 2 (two) doses.
- Varicella:** 1 (one) dose.
- Hepatitis B:** 3 (three) doses.

If your child **has not** received these immunizations, **please obtain them as soon as possible**, and **send a copy of the immunization report from the physician to the school**. If your child has received these immunizations, **please send a copy of the immunization report from the physician to the school**.

**Please return this checklist and all the above forms.**

We appreciate your cooperation.

GBCS Nurse's Office  
(732)-448-1052 ext 134  
Nurse Carisma; [carisma.lambert@greaterbrunswick.org](mailto:carisma.lambert@greaterbrunswick.org)  
Nurse Ambika; [ambika.sharma@greaterbrunswick.org](mailto:ambika.sharma@greaterbrunswick.org)



# 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) <i>(First)</i>	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /	
Does Child Have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> 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>I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.</i>			
Signature/Date		This form may be released to WIC. <input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER			
Date of Physical Examination:		Results of physical examination normal? <input type="checkbox"/> Yes <input type="checkbox"/> 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)	

<b>IMMUNIZATIONS</b>	<input type="checkbox"/> Immunization Record Attached <input type="checkbox"/> Date Next Immunization Due: _____
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MEDICAL CONDITIONS		
Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	<input type="checkbox"/> None <input type="checkbox"/> 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: <input type="checkbox"/> Capillary <input type="checkbox"/> Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

<input type="checkbox"/> <i>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.</i>	
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](http://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](http://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 health 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.

# Asthma Treatment Plan – Student

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



Sponsored by  
AMERICAN LUNG ASSOCIATION



(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

**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
<input type="checkbox"/> Advair <sup>®</sup> HFA <input type="checkbox"/> 45, <input type="checkbox"/> 115, <input type="checkbox"/> 230	2 puffs twice a day
<input type="checkbox"/> Aerospir <sup>™</sup>	<input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs twice a day
<input type="checkbox"/> Alvesco <sup>®</sup> <input type="checkbox"/> 80, <input type="checkbox"/> 160	<input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs twice a day
<input type="checkbox"/> Dulera <sup>®</sup> <input type="checkbox"/> 100, <input type="checkbox"/> 200	2 puffs twice a day
<input type="checkbox"/> Flovent <sup>®</sup> <input type="checkbox"/> 44, <input type="checkbox"/> 110, <input type="checkbox"/> 220	2 puffs twice a day
<input type="checkbox"/> Qvar <sup>®</sup> <input type="checkbox"/> 40, <input type="checkbox"/> 80	<input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs twice a day
<input type="checkbox"/> Symbicort <sup>®</sup> <input type="checkbox"/> 80, <input type="checkbox"/> 160	<input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs twice a day
<input type="checkbox"/> Advair Diskus <sup>®</sup> <input type="checkbox"/> 100, <input type="checkbox"/> 250, <input type="checkbox"/> 500	1 inhalation twice a day
<input type="checkbox"/> Asmanex <sup>®</sup> Twisthaler <sup>®</sup> <input type="checkbox"/> 110, <input type="checkbox"/> 220	<input type="checkbox"/> 1, <input type="checkbox"/> 2 inhalations <input type="checkbox"/> once or <input type="checkbox"/> twice a day
<input type="checkbox"/> Flovent <sup>®</sup> Diskus <sup>®</sup> <input type="checkbox"/> 50 <input type="checkbox"/> 100 <input type="checkbox"/> 250	1 inhalation twice a day
<input type="checkbox"/> Pulmicort Flexhaler <sup>®</sup> <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 <sup>®</sup> (Budesonide) <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"/> Singulair <sup>®</sup> (Montelukast) <input type="checkbox"/> 4, <input type="checkbox"/> 5, <input type="checkbox"/> 10 mg	1 tablet daily
<input type="checkbox"/> Other	
<input type="checkbox"/> None	

## 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:
  - \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_

And/or Peak flow above \_\_\_\_\_

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: \_\_\_\_\_

**Continue daily control medicine(s) and ADD quick-relief medicine(s).**

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
<input type="checkbox"/> Albuterol MDI (Pro-air <sup>®</sup> or Proventil <sup>®</sup> or Ventolin <sup>®</sup> )	2 puffs every 4 hours as needed
<input type="checkbox"/> Xopenex <sup>®</sup>	2 puffs 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"/> Duoneb <sup>®</sup>	1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Xopenex <sup>®</sup> (Levalbuterol) <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"/> Combivent Respimat <sup>®</sup>	1 inhalation 4 times a day
<input type="checkbox"/> Increase the dose of, or add:	
<input type="checkbox"/> Other	

• If quick-relief medicine is needed more than 2 times a week, except before exercise, then call your doctor.

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 \_\_\_\_\_

## 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: \_\_\_\_\_

**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
<input type="checkbox"/> Albuterol MDI (Pro-air <sup>®</sup> or Proventil <sup>®</sup> or Ventolin <sup>®</sup> )	4 puffs every 20 minutes
<input type="checkbox"/> Xopenex <sup>®</sup>	4 puffs 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"/> Duoneb <sup>®</sup>	1 unit nebulized every 20 minutes
<input type="checkbox"/> Xopenex <sup>®</sup> (Levalbuterol) <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"/> Combivent Respimat <sup>®</sup>	1 inhalation 4 times a day
<input type="checkbox"/> Other	

And/or Peak flow below \_\_\_\_\_

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

**Disclaimers:** This asthma treatment plan is intended to assist in the management of asthma and is not a substitute for medical advice from a healthcare provider. It is not intended to be used in place of a physician's orders. The user assumes all responsibility for the use of this plan. The user agrees to indemnify and hold the sponsor harmless from any and all claims, damages, and expenses, including reasonable attorneys' fees, arising from the use of this plan. The sponsor makes no warranty, express or implied, regarding the accuracy, completeness, or reliability of the information contained herein. The sponsor is not liable for any adverse effects or consequences resulting from the use of this plan. The sponsor is not a healthcare provider and does not provide medical services. The sponsor is not responsible for the diagnosis, treatment, or management of any condition. The sponsor is not responsible for the results of any tests or procedures performed by the user. The sponsor is not responsible for the results of any treatment or management of any condition. The sponsor is not responsible for the results of any tests or procedures performed by the user. The sponsor is not responsible for the results of any treatment or management of any condition. The sponsor is not responsible for the results of any tests or procedures performed by the user.

### 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 \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_

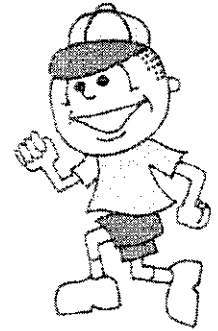
PHYSICIAN STAMP \_\_\_\_\_

REVISED MAY 2017

Permitted to reproduce blank form - www.aacp.org

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 doctor's name & phone number
  - Parent/Guardian's name & phone number
  - Child's date of birth
  - 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 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.

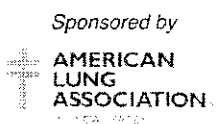
\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Date



**Disclaimers:** The PACNJ Asthma Treatment Plan is not intended to constitute a contract. It is a form of communication between the parent/guardian and the school district. The parent/guardian is responsible for providing accurate information. The school district is not responsible for the accuracy of the information provided. The parent/guardian is responsible for providing accurate information. The school district is not responsible for the accuracy of the information provided. The parent/guardian is responsible for providing accurate information. The school district is not responsible for the accuracy of the information provided.



PLACE  
PICTURE  
HERE

Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Allergic 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

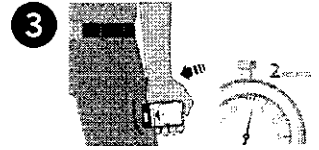
PHYSICIAN/HCP AUTHORIZATION SIGNATURE

DATE



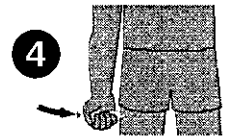
### HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

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



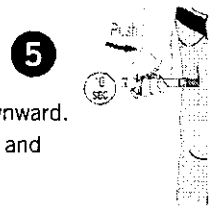
### HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

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



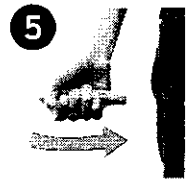
### HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

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



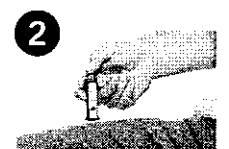
### HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

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



### HOW TO USE SYMJEPI™ (EPINEPHRINE INJECTION, USP)

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



### ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

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

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

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

#### EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: \_\_\_\_\_

DOCTOR: \_\_\_\_\_ PHONE: \_\_\_\_\_

PARENT/GUARDIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

#### OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

NAME/RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

NAME/RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_



# SEIZURE ACTION PLAN (SAP)



**END EPILEPSY**

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact/Relationship \_\_\_\_\_ Phone: \_\_\_\_\_

## Seizure Information

Seizure Type	How Long It Lasts	How Often	What Happens

### How to respond to a seizure (check all that apply)

- First aid – **Stay. Safe. Side.**
- Give rescue therapy according to SAP
- Notify emergency contact
- Notify emergency contact at \_\_\_\_\_
- Call 911 for transport to \_\_\_\_\_
- Other \_\_\_\_\_

### First aid for any seizure

- STAY** calm, keep calm, **begin timing seizure**
- Keep me **SAFE** – remove harmful objects, don't restrain, protect head
- SIDE** – turn on side if not awake, keep airway clear, don't put objects in mouth
- STAY** until recovered from seizure
- Swipe magnet for VNS
- Write down what happens \_\_\_\_\_
- Other \_\_\_\_\_

### When to call 911

- Seizure with loss of consciousness longer than 5 minutes, not responding to rescue med if available
- Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med if available
- Difficulty breathing after seizure
- Serious injury occurs or suspected, seizure in water

### When to call your provider first

- Change in seizure type, number or pattern
- Person does not return to usual behavior (i.e., confused for a long period)
- First time seizure that stops on its' own
- Other medical problems or pregnancy need to be checked

### When rescue therapy may be needed:

#### WHEN AND WHAT TO DO

If seizure (cluster, # or length) \_\_\_\_\_

Name of Med/Rx \_\_\_\_\_ How much to give (dose) \_\_\_\_\_

How to give \_\_\_\_\_

If seizure (cluster, # or length) \_\_\_\_\_

Name of Med/Rx \_\_\_\_\_ How much to give (dose) \_\_\_\_\_

How to give \_\_\_\_\_

If seizure (cluster, # or length) \_\_\_\_\_

Name of Med/Rx \_\_\_\_\_ How much to give (dose) \_\_\_\_\_

How to give \_\_\_\_\_

## Care after seizure

What type of help is needed? (describe) \_\_\_\_\_

When is person able to resume usual activity? \_\_\_\_\_

## Special instructions

First Responders: \_\_\_\_\_

Emergency Department: \_\_\_\_\_

## Daily seizure medicine

Medicine Name	Total Daily Amount	Amount of Tab/Liquid	How Taken (time of each dose and how much)

## Other information

Triggers: \_\_\_\_\_

Important Medical History \_\_\_\_\_

Allergies \_\_\_\_\_

Epilepsy Surgery (type, date, side effects) \_\_\_\_\_

Device:  VNS  RNS  DBS Date Implanted \_\_\_\_\_

Diet Therapy  Ketogenic  Low Glycemic  Modified Atkins  Other (describe) \_\_\_\_\_

Special Instructions: \_\_\_\_\_

## Health care contacts

Epilepsy Provider: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care: \_\_\_\_\_ Phone: \_\_\_\_\_

Preferred Hospital: \_\_\_\_\_ Phone: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_

My signature \_\_\_\_\_ Date \_\_\_\_\_

Provider signature \_\_\_\_\_ Date \_\_\_\_\_