PCA

Parents/Guardians,

Specific health information is required for all onsite and offsite students enrolled at PCA. Below is a guide to help you navigate the following pages.

Pages 2-4: *Required*
These pages are required to be filled out by a parent/guardian. Please note that your student will not be able to join us on campus until these 3 pages are complete and submitted.

Page 5: *Required*
You may use this form or a form provided by your student's physician as documentation of a physical examination. All enrolling students are required to have a physical within 1 calendar year of starting school. You are also required to submit proof of vaccination or a vaccine exemption form (found here: https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents/2021-11/exemption.pdf).

Page 6: *If below does not apply to your student, you may skip this page*
If your student will need medication to be administered during the school day or needs emergency medication (inhalers, epi-pens ect.) we require an order from the prescribing physician. You may use this form or an order provided by your student's physician.

Pages 7-11: *If below does not apply to your student, you may skip these pages*
If your student has a seizure disorder, asthma or a severe allergy the associated action plan must be filled out and signed by your physician and by a parent/guardian. If your physician has a form they prefer this is acceptable as well.

Please submit all forms to the PCA Health Office:
Email: nurse@pcaschool.org
Fax: 603-750-0490
In person: You may drop off all forms to the Lower School Receptionist.

Thank you and welcome to PCA!
PCA Nursing Team

PCA

Student Information

Name:

_____

Date of Birth:
_____/_____/_____

Address:_____

_____

☐ Male ☐ Female

Age: _____ Grade: _____

Phone: _____

Parent/Guardian Information

Name: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email: _____

Parent/Guardian Information

Name: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email: _____

Student lives with: _____

Please describe specific custody arrangements:

_____

_____

_____

Physician Information

Name: _____

Phone: _____

Dentist Information

Name: _____

Phone: _____

Allergy Information

Please list your child's allergies. If there are no allergies please write N/A in the appropriate space.

Medications: _____

_____

Foods: _____

_____

Environmental/Seasonal: _____

_____

Latex: _____

Other:_____

Does your child have a severe allergy to any of the above? Y N

Does your child require an Epi-Pen? Y N

Does your child self-carry an Epi-Pen? Y N

PCA

HEALTH INFORMATION

Please indicate the following for your student:

	Yes	No		Yes	No
High blood pressure			Hearing loss		
Heart condition (murmur, palpitation, etc.)			Scoliosis		
Asthma			Dental problems		
Severe allergies			Restriction from sports		
Contact with tuberculosis			Orthopedic problems (sprains, broken bones)		
Surgery			English is a second language		
Tumor, growth, or cancer			Previous Hospitalization		
Diabetes			Special equipment (braces, etc.)		
Serious skin disease			Adverse response to exercise		
Concussion or head injury			Family history of heart conditions		
Frequent or severe headache			Skin issues (itching, rashes, etc.)		
Dizziness or fainting spells			Pinched nerve		
Severe head injury			Muscle cramping		
Epilepsy, seizures			FEMALES:		
Developmental problems/delays			Date of first menstrual period?:		
Excessive worry or anxiety			Date of last menstrual period?:		
Depression			Longest time between periods?:		
Behavioral/attention problems			Other important health information:		
Chronic abdominal pain					
Intestinal trouble					
Speech problems					
Eye problems					
Wears glasses/contacts					
Frequent ear infections					

Please explain anything indicated with a "yes:"

PCA

ORDER FOR OVER-THE-COUNTER MEDICATION

Student's Name: _____ Date of Birth: ___/____/_____

I give permission for the school nurse, or the principal's designee, to administer to my child the following over-the-counter medications, as appropriate:

	Yes	No
Motrin/Advil (Ibuprofen)	☐	☐
Tylenol (Acetaminophen)	☐	☐
Benadryl	☐	☐

Any other over-the-counter medication should be brought in to PCA by the parents with specific instructions for use (i.e cough drops, Aleve, Lactaid, etc).

_____
Parent/Guardian's Name

_____ _____
Parent/Guardian's Signature Date

Allergies: (to medications, foods, insects, latex, other):

_____

_____

********** I give permission to the PCA nurse, or the principal's designee, to administer epinephrine in the event that my child experiences a severe, life-threatening, anaphylactic allergic reaction at school. I understand that in the event of this occurrence an ambulance will be summoned and emergency treatment will be given to my child.

_____ _____
Parent/Guardian's Signature Date

PCA

PHYSICAL EXAMINATION FORM

Student Name: _____ DOB: _____

Height: _____ Percentile: _____ B/P: _____ U/A: _____
Weight: _____ Percentile: _____ Pulse: _____ Hgb/Hct: _____

Lead Level 1y/o: _____ Lead Level 2 y/o: _____

Allergies:

_____

_____

	Normal	Abnormal	If abnormal, explain:
Hair/Scalp	☐	☐	
Skin	☐	☐	
Eyes – visual acuity R____ L____	☐	☐	
Eyes – color vision	☐	☐	
Hearing – dB R____L____	☐	☐	
Nose and Throat	☐	☐	
Teeth and Gingiva	☐	☐	
Speech	☐	☐	
Lymph Glands	☐	☐	
Cardiovascular	☐	☐	
Respiratory (asthma, etc.)	☐	☐	
Abdomen	☐	☐	
Gastrointestinal	☐	☐	
Genitalia	☐	☐	
Neurological	☐	☐	
Seizure Disorders	☐	☐	
Muscular System	☐	☐	
Extremities	☐	☐	
Orthopedic (including scoliosis)	☐	☐	
Other	☐	☐	

*Impression of child's present state of health:_____

*Restrictions from sports/activities:_____

*Recommendations regarding:
Medical Needs:_____

Developmental Needs:_____

Family Support:_____

Please provide allergy/asthma/diabetic/epileptic/epi-pen/etc. action plans to parent/guardian.
Please provide most recent immunization record.

Signature of Physician/APRN/PA: _____ Date: _____

Printed name of Physician/APRN/PA: _____ Phone: _____

PCA

PRESCRIPTION MEDICATION ADMINISTRATION ORDER

Name: _____DOB: ____/_____/_____

Medication/Dose: _____

Route: _____

Frequency: _____

Time: _____

Reason: _____

Does this medication need to be taken with food or on an empty stomach?:

_____

Are there any other instructions for administration?:

_____

If an Emergency Medication, does student have permission to self-carry?:

Y N

Provider Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Allergy and Anaphylaxis Emergency Plan

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Child's name: _____ **Date of plan:** _____

Date of birth: ____/____/_____ **Age** _____ **Weight:** _____kg

Child has allergy to _____

Attach child's photo

Child has asthma. ☐ Yes ☐ No (If yes, higher chance severe reaction)
Child has had anaphylaxis. ☐ Yes ☐ No
Child may carry medicine. ☐ Yes ☐ No
Child may give him/herself medicine. ☐ Yes ☐ No (If child refuses/is unable to self-treat, an adult must give medicine)

IMPORTANT REMINDER
Anaphylaxis is a potentially life-threating, severe allergic reaction. If in doubt, give epinephrine.

For Severe Allergy and Anaphylaxis
What to look for

If child has ANY of these severe symptoms after eating the food or having a sting, **give epinephrine.**

- Shortness of breath, wheezing, or coughing
- Skin color is pale or has a bluish color
- Weak pulse
- Fainting or dizziness
- Tight or hoarse throat
- Trouble breathing or swallowing
- Swelling of lips or tongue that bother breathing
- Vomiting or diarrhea (if severe or combined with other symptoms)
- Many hives or redness over body
- Feeling of "doom," confusion, altered consciousness, or agitation

☐ **SPECIAL SITUATION**: If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s): _____. Even if child has MILD symptoms after a sting or eating these foods, **give epinephrine.**

Give epinephrine!
What to do

1. Inject epinephrine right away! Note time when epinephrine was given.
2. Call 911.
   - Ask for ambulance with epinephrine.
   - Tell rescue squad when epinephrine was given.
3. Stay with child and:
   - Call parents and child's doctor.
   - Give a second dose of epinephrine, if symptoms get worse, continue, or do not get better in 5 minutes.
   - Keep child lying on back. If the child vomits or has trouble breathing, keep child lying on his or her side.
4. Give other medicine, if prescribed. Do not use other medicine in place of epinephrine.
   - Antihistamine
   - Inhaler/bronchodilator

For Mild Allergic Reaction
What to look for

If child has had any mild symptoms, **monitor child.**
Symptoms may include:

- Itchy nose, sneezing, itchy mouth
- A few hives
- Mild stomach nausea or discomfort

Monitor child
What to do

Stay with child and:

- Watch child closely.
- Give antihistamine (if prescribed).
- Call parents and child's doctor.
- If more than 1 symptom or symptoms of severe allergy/anaphylaxis develop, use epinephrine. (See "For Severe Allergy and Anaphylaxis.")

Medicines/Doses

Epinephrine, intramuscular (list type): _____ Dose: ☐ 0.10 mg (7.5 kg to less than13 kg)*
☐ 0.15 mg (13 kg to less than 25 kg)
☐ 0.30 mg (25 kg or more)

Antihistamine, by mouth (type and dose): _____ (*Use 0.15 mg, if 0.10 mg is not available)

Other (for example, inhaler/bronchodilator if child has asthma): _____

_____ _____ _____ _____
Parent/Guardian Authorization Signature **Date** **Physician/HCP Authorization Signature** **Date**

Allergy and Anaphylaxis Emergency Plan

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Child's name: _____ **Date of plan:** _____

Additional Instructions:

Contacts

Call 911 / Rescue squad: _____

Doctor: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Other Emergency Contacts

Name/Relationship: _____ Phone: _____

Name/Relationship: _____ Phone: _____

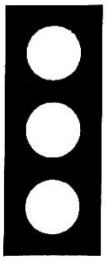
 Your child's doctor will tell you to do what's best for your child. This information should not take the place of talking with your child's doctor. Page 2 of 2.

ASTHMA ACTION PLAN

Asthma and Allergy Foundation of America
aafa.org

Name:	Date:
Doctor:	Medical Record #:
Doctor's Phone #: Day	Night/Weekend
Emergency Contact:	
Doctor's Signature:	

The colors of a traffic light will help you use your asthma medicines.



GREEN means Go Zone!
Use preventive medicine.

YELLOW **means Caution Zone!**
Add quick-relief medicine.

RED means Danger Zone!
Get help from a doctor.

Personal Best Peak Flow: _____

GO

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

Peak flow:
from _____
to _____

Use these daily controller medicines:

MEDICINE	HOW MUCH	HOW OFTEN/WHEN
For asthma with exercise, take:		

CAUTION

You have *any* of these:
- First signs of a cold
- Exposure to known trigger
- Cough
- Mild wheeze
- Tight chest
- Coughing at night

Peak flow:
from _____
to _____

Continue with green zone medicine and add:

MEDICINE	HOW MUCH	HOW OFTEN/ WHEN
CALL YOUR ASTHMA CARE PROVIDER.		

DANGER

Your asthma is getting worse fast:
- Medicine is not helping
- Breathing is hard & fast
- Nose opens wide
- Trouble speaking
- Ribs show (in children)

Peak flow:
reading below _____

Take these medicines and call your doctor now.

MEDICINE	HOW MUCH	HOW OFTEN/WHEN

GET HELP FROM A DOCTOR NOW! Your doctor will want to see you right away. It's important!
If you cannot contact your doctor, go directly to the emergency room. DO NOT WAIT.
Make an appointment with your asthma care provider within two days of an ER visit or hospitalization.

SCHOOL SEIZURE ACTION PLAN

ABOUT

Name _____ Date of Birth _____

Doctors Name _____ Phone _____

Emergency Contact Name _____ Phone _____

Emergency Contact Name _____ Phone _____

Seizure Type/Name: _____

What Happens: _____

How Long It Lasts: _____

How Often: _____

Seizure Triggers:

☐ Missed Medicine ☐ Emotional Stress ☐ Alcohol/Drugs ☐ Menstrual Cycle ☐ Missing meals

☐ Lack of Sleep ☐ Physical Stress ☐ Flashing Lights ☐ Illness with high fever

☐ Response to specific food, or excess caffeine Specify: _____ ☐ Other Specify: _____

DAILY TREATMENT PLAN

Seizure Medicine(s)

Name	How Much	How Often/When

Additional Treatment/Care: (i.e.: diet, sleep, devices etc.)

CAUTION–STEP UP TREATMENT

Symptoms that signal a seizure may be coming on and additional treatment may be needed:

☐ Headache ☐ Staring Spells ☐ Confusion ☐ Dizziness ☐ Change in Vision/Auras

☐ Sudden Feeling of Fear or Anxiety ☐ Other Specify: _____

Additional Treatment:

☐ Continue Daily Treatment Plan

- If missed medicine, give prescribed dose from above ASAP.
- Do not give a double dose or give meds closer than 6 hours apart.

☐ Change to: _____ How Much: _____ How Often/When: _____

☐ Add: _____ How Much: _____ How Often/When: _____

☐ Other Treatments/Care: (i.e.: sleep, devices): _____

SCHOOL SEIZURE ACTION PLAN

DANGER–GET HELP NOW

Follow Seizure First Aid Below

☐ Contact School Nurse or Adult trained on rescue medication:

Name:_____ Number:_____

☐ Record Duration and time of each seizure(s)

☐ Call 911 if:

- Student has a convulsive seizures lasting more than___minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student is having breathing difficulty

When EMS arrives, a medical provider will perform an individual assessment to determine appropriate next steps.

Rescue Therapy:

☐ Rescue therapy provided according to physician's order:

_____

_____

POST SEIZURE RECOVERY

Typical Behaviors/Needs After Seizure:

☐ Headache ☐ Drowsiness/Sleep ☐ Nausea ☐ Aggression ☐ Confusion/Wandering ☐ Blank Staring

☐ Other Specify:_____

Reviewed/Approved by:

_____

Physician Signature Date

_____

Parent/Guardian Signature Date

SEIZURE FIRST AID

Image adapted with permission from the Epilepsy Foundation of America

LEARN MORE AND GET A DOWNLOADABLE VERSION OF THIS ACTION PLAN AT:

Child Neurology FOUNDATION
Creating a Community of Support
childneurologyfoundation.org/sudep

Danny Did FOUNDATION
dannydid.org

EPILEPSY FOUNDATION
SUDEP INSTITUTE
epilepsy.com/sudep-institute