

**Northern Burlington County Regional School District
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Columbus, NJ 08022**

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ASTHMA AWARENESS QUESTIONNAIRE

Asthma is a chronic, inflammatory lung disease involving recurrent breathing problems. It is a condition that has generally not been treated as seriously as other chronic diseases. However, according to the National Institute of Allergy and Infectious Diseases asthma is the most common serious disease among children in the United States. It is blamed for more than 5,000 deaths per year and 10 million school absences.

The incidence of diagnosed asthma has increased significantly over the last two decades. Even though extensive research has taken place during this time, the disease is still misunderstood. Many times it is not treated as aggressively as it could be. Worst yet it is not treated at all.

Because of the serious implications of asthma, Northern Burlington County Regional School District is taking a proactive stance by gathering more information. With this information we can better identify athletes at risk, help asthmatic athletes achieve maximum performance under the safest conditions and possibly help prevent a tragedy.

Thank you for your cooperation. If you have any questions or concerns, please contact:
In the High School: Diane Applegate RN, MSN, Laura Tewes RN or Erin Cearfoss ATC.
In the Middle School: Eileen Mancini RN, BSN

All students should complete this document.

Name _____
Age: _____ Height: _____ Weight: _____

	Yes	No
1. Do you ever have wheezing?	_____	_____
2. Does running ever cause chest tightness or cough or wheezing or prolonged shortness of breath?	_____	_____
3. Have you ever had chest tightness, cough, wheezing, asthma or other? Chest (lung) problems that make it difficult for you to perform in sports?	_____	_____
4. Have you ever missed school, work or practice because of lung disease? (pneumonia) chest tightness or cough or wheezing or prolonged shortness of breath?	_____	_____
5. Do you have trouble breathing or do you cough (locker room cough) during or after activity?	_____	_____

_____ My son/daughter has **never** been diagnosed with asthma, exercise induced asthma, broncho spasm nor have they ever had any breathing difficulty.

_____ My son/daughter has been diagnosed with asthma, exercise induced asthma or some form of respiratory problem. **Attached form is required to be filled out by treating physician.**

My son/daughter is: _____ taking medication to control their problem.
_____ not currently taking medication and rarely experiences any breathing difficulty.

Student athlete signature Date Parent/Guardian signature Date

If student has been diagnosed with asthma, the attached Asthma Action Plan form is required to be completed by treating physician.

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.

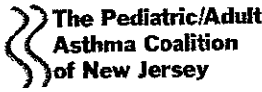
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Asthma Treatment Plan

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



Your Pathway to Asthma Control
MCHN 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



Take daily medicine(s). Some metered dose inhalers may be more effective with a "spacer" - use if directed



You have **all** of these:

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

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

Remember to rinse your mouth after taking inhaled medicine.

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:

And/or Peak flow above _____

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

CAUTION



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



You have **any** of these:

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

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

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

And/or Peak flow from _____ to _____

EMERGENCY



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



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

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

REVISED MAY 2009
mission to reproduce this form.
www.pacnj.org

FOR MINORS ONLY:

- 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 _____

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

New Jersey Department of Education COMPREHENSIVE PHYSICAL EXAMINATION FORM

Part A: HEALTH HISTORY QUESTIONNAIRE-Completed by the parent and student and reviewed by examining provider
Part B: PHYSICAL EVALUATION FORM-Completed by examining licensed provider with MD, DO, APN or PA

Part A: HEALTH HISTORY QUESTIONNAIRE

Today's Date: _____ Date of Last Sports Physical: _____

Student's Name: _____ Sex: M F (circle one) Age: _____ Grade: _____

Date of Birth: ___/___/___ School: _____ District: _____

Sport(s): _____ Home Phone: (____) _____

Provider Name (Medical Home): _____ Phone: _____ Fax: _____

EMERGENCY CONTACT INFORMATION

Name of parent/guardian: _____ Relationship to student: _____

Phone (work): _____ Phone (home): _____ Phone (cell): _____

Additional emergency contact: _____ Relationship to student: _____

Phone (work): _____ Phone (home): _____ Phone (cell): _____

Directions: Please answer the following questions about the student's medical history by **CIRCLING** the correct response. Explain all "yes" responses on the lines below the questions. Please respond to all questions.

1. Have you ever had, or do you currently have:
 - a. Restriction from sports for a health related problem? Y/N/Don't Know
 - b. An injury or illness since your last exam? Y/N/Don't Know
 - c. A chronic or ongoing illness (such as diabetes or asthma)? Y/N/Don't Know
 - (1.) An inhaler or other prescription medicine to control asthma? Y/N/Don't Know
 - d. Any prescribed or over the counter medications that you take on a regular basis? Y/N/Don't Know
 - e. Surgery, hospitalization or any emergency room visit(s)? Y/N/Don't Know
 - f. Any allergies to medications? Y/N/Don't Know
 - g. Any allergies to bee stings, pollen, latex or foods? Y/N/Don't Know
 - (1.) If yes, check type of reaction:
 - Rash Hives Breathing or other anaphylactic reaction
 - (2.) Take any medication/Epipen taken for allergy symptoms? (List below.) Y/N/Don't Know
 - h. Any anemias, blood disorders, sickle cell disease/trait, bleeding tendencies or clotting disorders? Y/N/Don't Know
 - i. A blood relative who died before age 50? Y/N/Don't Know

Explain all "yes" answers here (include relevant dates):

List all medications here:

Medication Name	Dosage	Frequency

2. Have you ever had, or do you currently have, any of the following *head-related* conditions:
- | | |
|---|--------------------|
| a. Concussion or head injury (including "bell rung" or a "ding")? | Y / N / Don't Know |
| b. Memory loss? | Y / N / Don't Know |
| c. Knocked out? | Y / N / Don't Know |
| d. A seizure? | Y / N / Don't Know |
| e. Frequent or severe headaches (With or without exercise)? | Y / N / Don't Know |
| f. Fuzzy or blurry vision | Y / N / Don't Know |
| f. Sensitivity to light/noise | Y / N / Don't Know |

Explain all "yes" answers here (include relevant dates):

3. Have you ever had, or do you currently have, any of the following *heart-related* conditions:
- | | |
|--|--------------------|
| a. Restriction from sports for heart problems? | Y / N / Don't Know |
| b. Chest pain or discomfort? | Y / N / Don't Know |
| c. Heart murmur? | Y / N / Don't Know |
| d. High blood pressure? | Y / N / Don't Know |
| e. Elevated cholesterol level? | Y / N / Don't Know |
| f. Heart infection? | Y / N / Don't Know |
| g. Dizziness or passing out during or after exercise without known cause? | Y / N / Don't Know |
| h. Has a provider ever ordered a heart test (EKG, echocardiogram, stress test, Holter monitor)? | Y / N / Don't Know |
| i. Racing or skipped heartbeats? | Y / N / Don't Know |
| j. Unexplained difficulty breathing or fatigue during exercise? | Y / N / Don't Know |
| k. Any family member (blood relative): | |
| (1.) Under age 50 with a heart condition? | Y / N / Don't Know |
| (2.) With Marfan Syndrome? | Y / N / Don't Know |
| (3.) Died of a heart problem before age 50? If yes, at what age? _____ | Y / N / Don't Know |
| (4.) Died with no known reason? | Y / N / Don't Know |
| (5.) Died while exercising? If yes, was it during or after? (Circle one.) | Y / N / Don't Know |

Explain all "yes" answers here (include relevant dates):

4. Have you ever had, or do you currently have, any of the following *eye, ear, nose, mouth or throat* conditions:
- | | |
|---|--------------------|
| a. Vision problems? | Y / N / Don't Know |
| (1.) Wear contacts, eyeglasses or protective eye wear? (Circle which type.) | Y / N / Don't Know |
| b. Hearing loss or problems? | Y / N / Don't Know |
| (1.) Wear hearing aides or implants? | Y / N / Don't Know |
| c. Nasal fractures or frequent nose bleeds? | Y / N / Don't Know |
| d. Wear braces, retainer or protective mouth gear? | Y / N / Don't Know |
| e. Frequent strep or any other conditions of the throat (e.g. tonsillitis)? | Y / N / Don't Know |

Explain all "yes" answers here (include relevant dates):

5. Have you ever had, or do you currently have, any of the following *neuromuscular/orthopedic* conditions:
- | | |
|---|--------------------|
| a. Numbness, a "burner", "stinger" or pinched nerve? | Y / N / Don't Know |
| b. A sprain? | Y / N / Don't Know |
| c. A strain? | Y / N / Don't Know |
| d. Swelling or pain in muscles, tendons, bones or joints? | Y / N / Don't Know |
| e. Dislocated joint(s)? | Y / N / Don't Know |
| f. Upper or lower back pain? | Y / N / Don't Know |
| g. Fracture(s), stress fracture(s), or broken bone(s)? | Y / N / Don't Know |
| h. Do you wear any protective braces or equipment? | Y / N / Don't Know |

Explain all (yes) answers here (include relevant dates):

6. Have you ever had or do you currently have any of the following *general or exercise related* conditions:
- | | |
|--------------------------|--------------------|
| a. Difficulty breathing? | Y / N / Don't Know |
| (1.) During exercise? | Y / N / Don't Know |

- | | |
|---|--------------------|
| (2.) After running one mile? | Y / N / Don't Know |
| (3.) Coughing, wheezing or shortness of breath in weather changes? | Y / N / Don't Know |
| (4.) Exercise-induced asthma? | Y / N / Don't Know |
| i. Controlled with medication? (specify _____) | Y / N / Don't Know |
| ii. Experience dizziness, passing out or fainting? | Y / N / Don't Know |
| b. Viral infections (e.g. mono, hepatitis, coxsackie virus)? | Y / N / Don't Know |
| c. Become tired more quickly than others? | Y / N / Don't Know |
| d. Any of the following skin conditions: | Y / N / Don't Know |
| (1.) Cold sores/herpes, impetigo, MRSA, ringworm, warts? | Y / N / Don't Know |
| (2.) Sun sensitivity? | Y / N / Don't Know |
| e. Weight gain/loss (of 10 pounds or more)? | Y / N / Don't Know |
| (1.) Do you want to weigh more or less than you do now? | Y / N / Don't Know |
| f. Ever had feelings of depression? | Y / N / Don't Know |
| g. Heat-related problems (dehydration, dizziness, fatigue, headache)? | Y / N / Don't Know |
| (1.) Heat exhaustion (cool, clammy, damp skin)? | Y / N / Don't Know |
| (2.) Heat stroke (hot, red, dry skin)? | Y / N / Don't Know |
| (3.) Muscle cramps? | Y / N / Don't Know |
| h. Absence or loss of an organ (e.g. kidney, eyeball, spleen, testicle, ovary)? | Y / N / Don't Know |

Explain all "yes" answers here (include relevant dates):

7. Females only:

Age of onset of menstruation: _____ How many menstrual periods in the last twelve (12) months? _____

How many periods missed in the last twelve (12) months? _____

8. Males only:

Have you had any swelling or pain in your testicles or groin?

Y / N / Don't Know

PARENT/GUARDIAN SIGNATURE

I certify that the information provided herein is accurate to the best of my knowledge as of the date of my signature.

Signature, Parent/Guardian or Student Age 18

Date of Signature:

THIS COMPLETED AND SIGNED HEALTH HISTORY MUST BE REVIEWED BY THE EXAMINING PROVIDER AT THE TIME OF THE MEDICAL EXAM.

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SUBJECT: Medication at School

Our medication policy encourages parents to administer all medications at home; however, it is recognized that children with special needs, chronic illnesses, and specific disabilities may require medication during the school day.

We therefore require a physician's approval and a written parental consent to accompany all medication both prescription and non-prescription (over-the-counter).

All medication must be brought to the school by parents/guardians and it will be kept locked in the nurse's office. The bottle should be clearly labeled with the child's name, name and strength of medication, drugstore where purchased, name of prescribing physician, and the time and amount of medication to be given.

The written statement from the physician must identify:

- Child's name and age
- Name and strength of medication
- Dosage, time to be given in school
- Purpose of medication
- Dates of administration

A written statement from the family physician must be brought in each September for those students who are on continuous daily medication

Student's Name _____ Age _____ Grade _____

Name and Strength of Medication _____ Dosage _____

Time and Route of Administration in school _____

Reason for Medication _____

Effective Dates: From _____ 20__ to _____ 20__

Most common side effects: _____

It is my understanding that the School Nurse charged with the administration of medication may rely upon my directions as contained in this document. I further certify that I am the physician who prescribed the medication and that the student named above is under my supervision as a patient for diagnosis and treatment. Any alteration to the above will occur only with written directions from the attending physician.

Doctor's Name (Print)

Doctor's Signature

Patient's Medication Allergies

Doctor's Address

Date

Doctor's Telephone Number

Date

Parent's Signature

Northern Burlington Regional School District Emergency Information Form

School Year _____

Student Name _____ Date of Birth _____ Male ___ Female ___ Gr. _____
(last) (first)

Home Address _____ Zip _____ Home Phone _____

Student lives with: ___ Mother ___ Father ___ Guardian ___ Other _____

Emergency Contacts : Only contacts listed on this emergency card will be permitted to pick your child up from school

Mother's/ Guardian's Name _____ Address _____ (if different from student)
Phone # _____ work phone # _____ cell phone # _____

Father's/ Guardian's Name _____ Address _____ (if different from student)
Phone # _____ work phone # _____ cell phone # _____

List two neighbors or nearby relatives who will assume temporary care of your child if you cannot be reached :

1. _____
name relationship cell # home # work #

2. _____
name relationship cell# home # work#

Please list other children attending New Jersey Public Schools (Name, School)

Does student have Health Insurance?

YES ___ If, Yes, name of insurance company _____

NO ___ NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information call 800-701-0710 or visit www.njfamilycare.org to apply online. You may release my name and address to the NJ FamilyCare Program to contact me about health insurance.

Signature: _____ Printed Name _____ Date: _____

Written consent required pursuant to 20 U.S.C. & 1232g (b)(1) and 34 C.F.R. 99.30 (b)

Scoliosis:

*The State of NJ requires that all children age 10-18 be screened for Scoliosis (curvature of the spine) every other year.

___ Yes, I want my child screened for Scoliosis at school.

___ No, My child will be screened for Scoliosis by our private physician. I will send a report of this exam to school.

Physical Examinations:

Students must receive routine medical exams upon entry into school. It is also recommended that students receive subsequent medical exams at least once during each developmental stage. Student Medical Examinations should be given by the child's primary health care provider.

*Students are screened annually by the school nurse, for height, weight, vision, hearing and blood pressure.

I, the undersigned, do hereby authorize officials of New Jersey Public Schools to contact directly the persons named on this card.

In the event that persons named on this card, or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child.

I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

Signature of Parent(s)/Guardian(s) _____

Date _____