The Calais School

Exceed Your Possibilities
45 Highland Ave, Whippany NJ 07981 973-884-2030 www.thecalaisschool.org

John Cohrs, M.Ed. *Executive Director*
Theresa Fritzky, M.Ed. *Principal*
Patrick Cooper, M.Ed. *Assistant Principal*

THE CALAIS SCHOOL INFORMATION PACKET 2025-2026

Dear Parents/Guardians,

Please complete the enclosed forms and return them to the main office using the checklist below. **Please note that your student will not be able to attend the 2025 Extended Year Program or 2025-2026 school year without these forms completed and returned to the main office. The due date for forms is June 15, 2025.**

Thank you for taking the time to complete and these forms. If you have any questions, please contact the school directly at (973) 884-2030. The school office is open daily from 7:30 A.M. until 4:00 P.M.

We appreciate your cooperation and look forward to a happy and productive school year!

Sincerely,
Kaitlin Kaminski and Christina Pedersen
The Calais School Main Office

INFORMATION PACKET CHECKLIST 2025-2026

MEDICAL FORMS FOR **PARENT** TO COMPLETE:

1. Student Medical Information Form
2. Counseling Treatment/Consent Form
3. Release for Emergency Medical Treatment
4. Scoliosis Screening Permission
5. Consent to Administer Over-the-Counter Medication in School

MEDICAL FORMS FOR **DOCTOR** TO COMPLETE ***IF APPLICABLE***:

1. School Nurse Prescription Medication Form
2. Care plans for Anaphylaxis, Asthma, Seizures
3. Limited Gym Form
4. Universal Child Health Record **(New Students Only)**

MEDICAL FORMS FOR **DOCTOR IF Grade 9-12 STUDENT WANTS TO PARTICIPATE IN INTERSCHOLASTIC BASKETBALL AND/OR TRACK**:

1. Pre-Participation Physical Exam Form and History Form (To remain in doctor's office)
2. Pre-Participation Physical Evaluation Medical Eligibility Form (Return to School)

The Calais School

Parent **STUDENT MEDICAL INFORMATION** Date: _____

STUDENT_____ D.O.B._____

FAMILY DOCTOR_____ OFFICE PHONE_____

ADDRESS_____

FAMILY DENTIST_____ OFFICE PHONE_____

ADDRESS_____

SPECIALISTS

NAME_____ OFFICE PHONE_____

ADDRESS_____

HEALTH INFORMATION

Does your student have any chronic health conditions? YES____ NO____

If yes, please indicate:

___Asthma
___Kidney/Bladder
___Arthritis
___Diabetes
___Type 1 ___Type 2
___Heart
___Bleeding Disorders

___Bee Sting Allergy
___Anaphylaxis
___Other Allergy (list):
_____
_____

___Internal Irregularities
___Convulsive Seizures
___Sight Impairment
___Wears Glasses
___Deafness
___Surgical
___Fractures

Please explain ALL if yes:_____

PRESCRIPTION MEDICATION: Name and dosage:_____

_____

Time administered: At Home: _____ At School:_____

NON-PRESCRIPTION MEDICATION: Name and dosage:_____

_____

Time administered: At Home: _____ At School:_____

SPECIAL DIETARY RESTRICTIONS OR ADDITIONAL REQUESTS _____

_____

_____

_____ _____

Signature of Parent/Guardian Date

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The Calais School

Parent

COUNSELING SERVICES / CONSENT/ TREATMENT / MEDICATION FORM

Name of Child: _____

Is your child currently being treated by a mental health provider? Yes_____ No_____

Psychiatrist Name: _____ Phone: _____ Fax: _____

Psychologist Name: _____ Phone: _____ Fax: _____

Counselor Name: _____ Phone: _____ Fax: _____

Neurologist Name: _____ Phone: _____ Fax: _____

Pediatrician Name: _____ Phone: _____ Fax: _____

Is your child on medication? Yes____ No ____

Current medications	Past Medications and noticeable effects if any
1_____	_____
2_____	_____
3_____	_____
4_____	_____
5_____	_____

Treatment Consent

As the parent of the aforementioned child, I give the Calais Psychological Services Team providing treatment to my child, consent to speak to and exchange information with the providers listed above in an effort to coordinate better mental health services. This information by such contract will be used solely for counseling services and will remain strictly confidential. This authorization is voluntary and I may cancel this consent at any time by sending written notice to the Principal of the Calais School, 45 Highland Avenue, Whippany NJ 07981 I understand that any release that was made prior to my cancellation in compliance with this authorization shall not constitute a breach of my rights and the student's rights to confidentiality.

By signing this form, I certify that I am a parent/guardian of this individual and fully understand my (our) rights and responsibilities under this agreement.

Parent Signature:_____ Date_____

The Calais School

Parent

RELEASE FOR EMERGENCY MEDICAL TREATMENT
2025-2026

Dear Parent or Guardian:

In case of medical emergency, it is imperative that the school be able to insure adequate and appropriate treatment for your child. In order to do so, a medical release is necessary. Please complete the release below and return it immediately to the school.

In the event of a medical emergency requiring professional medical attention while at school, your child will be taken to Morristown Medical Center by ambulance. You will be notified immediately. A designated staff member will accompany the child until you arrive.

Yours sincerely,
Theresa Fritzky
Principal

****

I, Mr./Mrs./Ms._____ hereby grant permission to

The Calais School to take my child _____

to an appropriate medical facility in order that he/she may be provided with emergency medical attention when required. Your signature below is not sufficient for the release of confidential information protected by law.

Special instructions: (Please indicate any allergies to medication, etc.)

_____

_____

_____ _____
Signature of Parent/Guardian Date

The Calais School

Parent

SCOLIOSIS SCREENING PERMISSION

Dear Parents/Guardians,

By Law, every New Jersey BOE/BOT must provide biennial scoliosis screening for students ages 10-18. "**N.J.S.A. 18A:40-43-Biennial Examination for Scoliosis".** The purpose of this screening is to detect signs of spinal curvature at its earliest stages so the need for treatment can be determined.

Scoliosis, the most common spinal abnormality, is a sideways curvature of the spine. Most cases of scoliosis are mild and only require observation by a physician after a diagnosis has been made. Early treatment can prevent the development of a severe deformity which can later affect the health and appearance of a child.

The screening procedure is simple. The school nurse will look at your child's back while he/she stands and bends forward. Boys and girls will be screened separately and individually. To assure a view of the spine we will request that students expose their backs during the screening.

You will be notified ONLY if medical follow-up is necessary. This screening does not replace your child's need for regular health care check-ups. If your child is already under observation or care for scoliosis by a physician your child will be exempt from screening.

Thank you for your cooperation. If you have any questions, please do not hesitate to contact the Calais School health office (ext. 218).

If your child is currently under active treatment for a spinal condition, or if you would rather not have your child screened, please complete and return this form to the school nurse by 6/15/25. ***If we do not receive this form then it will be assumed that we have your consent to provide the scoliosis screening for your child.***

Name of student_____

_____ Currently under treatment for a spinal condition.
_____ I do not want my child screened for scoliosis in school and will have their physician perform this screening.

Date:_____ Signature of Parent/Guardian_____

The Calais School

Parent

CONSENT TO ADMINISTER OVER-THE-COUNTER MEDICATION IN SCHOOL

In order for over-the-counter (OTC) medication to be given to your child during school by the nurse, this form needs to be completed by the child's parent or legal guardian.

Name _____ Grade _____ DOB _____Date _____

PARENT/GUARDIAN INFORMATION

Parent/Guardian Name	Parent/Guardian Name
_____	_____
Home Phone	Home Phone
_____	_____
Cell Phone	Cell Phone
_____	_____
Work Phone	Work Phone
_____	_____

PARENT/GUARDIAN CONSENT

The school nurse has permission to give my child the following over-the-counter (OTC) medications as per manufacturer's recommended dosing or prescription.

☐ Acetaminophen 325mg/500 mg tab	(Generic for TYLENOL)
☐ Ibuprofen 200mg tab	(Generic for ADVIL)
☐ Diphenhydramine 25 mg tab	(Generic for BENADRYL)
☐ Calcium Carbonate 500mg/700 mg tab	(Generic for TUMS)

Please note, **only Registered Nurses** may administer over-the-counter (OTC) medications in school under the written orders of the school physician. OTC medication will not be available for after school events or field trips. If your child needs OTC medications regularly, please contact the school nurse for a medication plan. **We will need written consent for any changes or to revoke.**

Sign Here			
	Parent/Guardian Signature	Print Name	Date

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The Calais School

Doctor ***(if applicable)***

School Nurse Authorization for Prescription Medication Administration This form is to be completed for all medications other than asthma medications and epinephrine.

*Original copy of this form is required by NJ State Law.
*State Law requires that medication be renewed each school year.
*Only one medication per form.

Name _____ Grade _____ DOB _____Date _____

Diagnosis _____

Allergies _____

Medication _____

Dosage _____ Time/Frequency _____ Route _____

Possible Side Effects _____

In the event that the student is not given their morning dose at home, the school nurse may give the medication listed above with parental permission. AM DOSE: _____

_____ _____ _____

Provider's Signature **Office Stamp** **Date**

Parent/Guardian Consent for Giving Medication During School

I request and give my consent for the School Nurse to dispense the medication prescribed by the physician on this form.

A prescription medication must be delivered to the School Nurse in the original pharmacy container labeled with the student's name, date of prescription, name of medication, dosage, and the prescribing physician's name. If the medication is an over-the-counter medicine, it must be in the original box.

I give permission for the information on this form to be shared with the appropriate staff members, coaches, and chaperones for the safety and welfare of my child.

I give permission for the school nurse to speak with the prescribing physician regarding the medication listed above, if necessary.

I request that my child be assisted in taking the medication described at school by the School Nurse or other individuals authorized to administer medication to students in school pursuant to N.J.A.C.:6A:16-2.3. I understand the ultimate responsibility for administering the medication is mine, and I am fully aware that the duties of the school nurse and others may require their presence at another location when the medication is needed.

_____ _____

Signature of Parent/Guardian **Date**

The Calais School

Doctor *(if applicable)* Anaphylaxis Individual Emergency Care Plan

Name: _____ DOB: _____

Allergy to: _____

Weight: _____ lbs. Asthma ☐ Yes (higher risk for a severe reaction) ☐ No

Does the student have a documented incident of anaphylaxis? ☐ Yes ☐ No

Extremely reactive to the following:_____

Therefore:

☐ Give epinephrine immediately for **ANY** symptoms if there was a likely exposure

☐ Give epinephrine immediately if there was exposure to the allergen, **even if no symptoms are noted**

Otherwise:

Any SEVERE SYMPTOMS after suspected or known exposure:

One or more of the following:
LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy confused
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Obstructive swelling (tongue and/or lips)
SKIN: Many hives over body
Or combination of symptoms from different body areas:
SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT: Vomiting, crampy pain

⇨

INJECT EPINEPHRINE IMMEDIATELY
Call 911
Begin monitoring (see box on next page)
Give additional medications *(If ordered)
Antihistamine
Inhaler (bronchodilator) if asthma

*Antihistamine & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis).
USE EPINEPHRINE

MILD SYMPTOMS ONLY:

MOUTH: Itchy mouth
SKIN: A few hives around mouth/face, mild itch
GUT: Mild nausea/discomfort

⇨

GIVE ANTIHISTAMINE
Stay with student; alert healthcare professional and parent
Dismiss student to care of parent or guardian
If symptoms progress (see above), USE EPINEPHRINE

Medication/Doses:

Epinephrine ☐ 0.15 mg or ☐ 0.3 mg ☐ May repeat dose in 15 minutes if symptoms continue

Antihistamine:_____

Other (e.g., inhaler-bronchodilator if asthmatic): _____

*Please note that by NJ state law the administration of epinephrine can be delegated to non-nursing staff.

Self-Administration:
☐ I have instructed the above student in the proper administration of epinephrine/antihistamine. It is my opinion that he/she is capable of self-administration. Student must notify the teacher or School Nurse when he/she has administered epinephrine/antihistamine.

OR

☐ It is my opinion that the above student **is not** capable of self-administration.

Contacts: Doctor: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Other Emergency Contact _____ Phone: _____

_____ _____
Parent/Guardian Signature Date

_____ _____
Healthcare Provider Signature Date

Dr.'s Office Stamp

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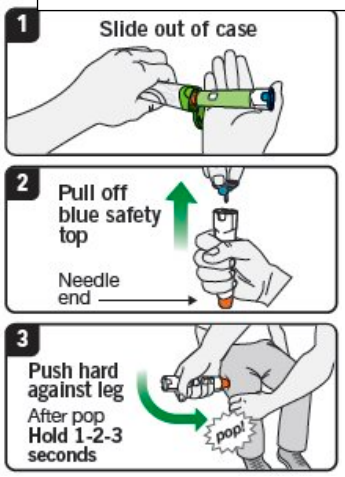
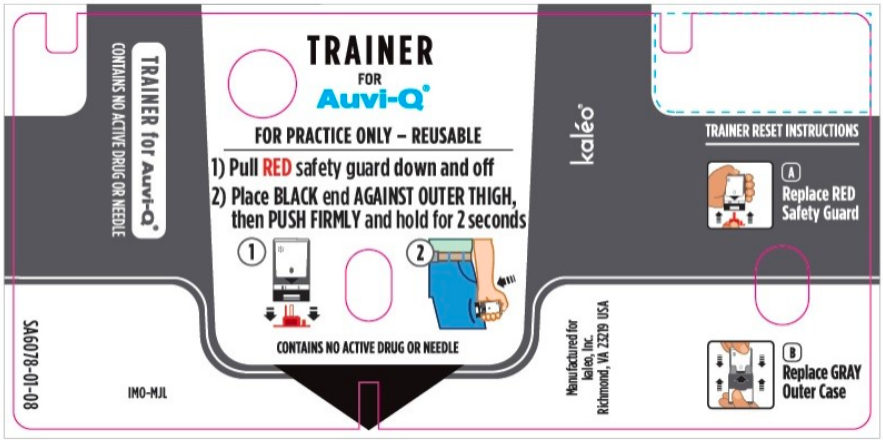
Doctor *(if applicable)*

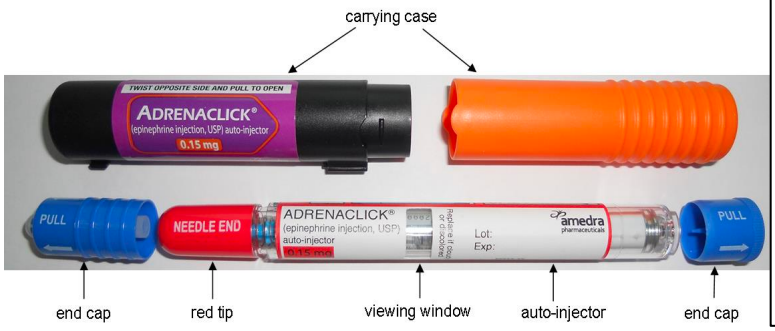
The Calais School

How to give EpiPen



How to give Auvi-Q





A food allergy response kit should contain at least 2 doses of epinephrine, other medications as noted by the student's doctor, and a copy of this anaphylaxis care plan. A kit must accompany the student if he/she is off school grounds. (i.e., field trip).
Monitoring: Stay with the student; alert healthcare professionals &

Parent Authorization

I hereby give permission for my child to receive medication at school as prescribed in the Anaphylaxis Emergency Care 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 accordance with state law 18A:40-12.5, I give permission for the school nurse to delegate the administration of epinephrine to my child when the school nurse is not immediately available. A copy of this plan will be shared with the delegate(s)/appropriate school personnel. I understand that the school and its employees or agents shall have no liability as a result of any injury arising from the administration of the epinephrine via a pre-filled auto-injector mechanism; and shall indemnify and hold harmless the school and its employees or agents against any claims arising out of administration of the epinephrine via a pre-filled auto-injector mechanism.

_____ _____

Parent/Guardian Signature Date

Fill out the section below only if your healthcare provider checked permission for your child to self-administer medication on the front of this form. *Recommendations are effective for the school year and must be renewed* ***annually.***

☐ I **do request** that my child be allowed to carry and self-administer medication 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 Anaphylaxis Emergency Care Plan for the current school year. 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, agents, and its employees shall incur no liability as stated above for any injury arising from the self-administration by the student of the medication prescribed on this form.

☐ I **DO NOT** request that my child self-administer his/her anaphylaxis medication.

_____ _____

Parent/Guardian Signature Date

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The Calais School

The Calais School

Doctor *(if applicable)*

Asthma Treatment Plan – Student
Parent Instructions

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

1. **Parents/Guardians:** *Before taking this form to your Health Care Provider,* complete the top left section with:
   - Child's name
   - Child's date of birth
   - Child's doctor's name & phone number
   - An Emergency Contact person's name & phone number
   - Parent/Guardian's name & phone number

2. **Your Health Care Provider will** complete the following areas:
   - The effective date of this plan
   - The medicine information for the Healthy, Caution and Emergency sections
   - Your Health Care Provider will check the box next to the medication and check how much and how often to take it
   - Your Health Care Provider may check **"OTHER" and:**
     - ❖ **Write in asthma medications not listed on the form**
     - ❖ **Write in additional medications that will control your asthma**
     - ❖ **Write in generic medications in place of the name brand on the form**
   - Together you and your Health Care Provider will decide what asthma treatment is best for your child to follow

3. **Parents/Guardians & Health Care Providers together** will discuss and then complete the following areas:
   - Child's peak flow range in the Healthy, Caution and Emergency sections on the left side of the form
   - Child's asthma triggers on the right side of the form
   - Permission to Self-administer Medication section at the bottom of the form: Discuss your child's ability to self-administer the inhaled medications, check the appropriate box, and then both you and your Health Care Provider must sign and date the form

4. **Parents/Guardians:** *After completing the form with your Health Care Provider:*
   - Make copies of the Asthma Treatment Plan and give the signed original to your child's school nurse or child care provider
   - Keep a copy easily available at home to help manage your child's asthma
   - Give copies of the Asthma Treatment Plan to everyone who provides care for your child, for example: babysitters, before/after school program staff, coaches, scout leaders

PARENT AUTHORIZATION

I hereby give permission for my child to receive medication at school as prescribed in the Asthma Treatment Plan. Medication must be provided in its original prescription container properly labeled by a pharmacist or physician. I also give permission for the release and exchange of information between the school nurse and my child's health care provider concerning my child's health and medications. In addition, I understand that this information will be shared with school staff on a need to know basis.

Parent/Guardian Signature _____ Phone _____ Date _____

FILL OUT THE SECTION BELOW ONLY IF YOUR HEALTH CARE PROVIDER CHECKED PERMISSION FOR YOUR CHILD TO SELF-ADMINISTER ASTHMA MEDICATION ON THE FRONT OF THIS FORM.

RECOMMENDATIONS ARE EFFECTIVE FOR ONE (1) SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY

☐ I do request that my child be **ALLOWED** to carry the following medication _____ for self-administration in school pursuant to N.J.A.C:.6A:16-2.3. I give permission for my child to self-administer medication, as prescribed in this Asthma Treatment Plan for the current school year as I consider him/her to be responsible and capable of transporting, storing and self-administration of the medication. Medication must be kept in its original prescription container. I understand that the school district, agents and its employees shall incur no liability as a result of any condition or injury arising from the self-administration by the student of the medication prescribed on this form. I indemnify and hold harmless the School District, its agents and employees against any claims arising out of self-administration or lack of administration of this medication by the student.

☐ I **DO NOT** request that my child self-administer his/her asthma medication.

Parent/Guardian Signature _____ Phone _____ Date _____

The Pediatric/Adult Asthma Coalition of New Jersey
"Your Pathway to Asthma Control"
PACNJ approved Plan available at www.pacnj.org

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 (ALA/M-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 of merchantability, non-infringement of third parties' rights, and fitness for a particular purpose. ALA/M-A makes no representations or warranties about the accuracy, reliability, completeness, currency, or timeliness of the content. ALA/M-A makes no warranty, representation or guaranty that the information on or will be uninterrupted, error free or that any defects can be corrected. In no event shall ALA/M-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 ALA/M-A is advised of the possibility of such damages. ALA/M-A and its affiliates are not liable for any claim, whatsoever, caused by your use or misuse of the Asthma Treatment Plan, nor of this website.

The Pediatric/Adult Asthma Coalition of New Jersey, sponsored by the American Lung Association in New Jersey. This publication was supported by a grant from the New Jersey Department of Health and Senior Services, with funds provided by the U.S. Centers for Disease Control and Prevention under Cooperative Agreement 5U58E=000451-5. Its content are solely the responsibility of the authors and do not necessarily represent the official views of the New Jersey Department of Health and Senior Services or the U.S. Centers for Disease Control and Prevention. Although this document has been funded wholly or in part by the United States Environmental Protection Agency under Agreement XA96256601 2 to the American Lung Association in New Jersey, it has not gone through the Agency's publications review process and therefore, may not necessarily reflect the views of the Agency and no official endorsement should be inferred. Information in this publication is not intended to diagnose health problems or take the place of medical advice. For asthma or any medical condition, seek medical advice from your child's or your health care professions.

Sponsored by AMERICAN LUNG ASSOCIATION® IN NEW JERSEY

Making a difference… one child at a time.

Doctor *(if applicable)*

Asthma Treatment Plan – Student

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

The Pediatric/Adult Asthma Coalition of New Jersey
"Your Pathway to Asthma Control"
PACNJ approved Plan available at www.pacnj.org

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NJ Health New Jersey Department of Health

(Please Print)

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

HEALTHY (Green Zone)

Take daily control medicine(s). Some 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

And/or Peak flow above ___________

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Advair® HFA ☐ 45, ☐ 115, ☐ 230	2 puffs twice a day
☐ Aerospan™	☐ 1 ☐ 2 puffs twice a day
☐ Alvesco® ☐ 80, ☐ 160	☐ 1 ☐ 2 puffs twice a day
☐ Dulera® ☐ 100, ☐ 200	2 puffs twice a day
☐ Flovent® ☐ 44, ☐ 110, ☐ 220	2 puffs twice a day
☐ Qvar® ☐ 40, ☐ 80	☐ 1 ☐ 2 puffs twice a day
☐ Symbicort® ☐ 80, ☐ 160	☐ 1 ☐ 2 puffs twice a day
☐ Advair Diskus® ☐ 100, ☐ 250, ☐ 500	1 inhalation twice a day
☐ Asmanex® Twisthaler® ☐ 110, ☐ 220	☐ 1 ☐ 2 inhalations ☐ once ☐ twice a day
☐ Flovent® Diskus® ☐ 50 ☐ 100 ☐ 250	1 inhalation twice a day
☐ Pulmicort Flexhaler® ☐ 90, ☐ 180	☐ 1 ☐ 2 inhalations ☐ once ☐ twice a day
☐ Pulmicort Respules® (Budesonide) ☐ 0.25, ☐ 0.5, ☐ 1.0	1 unit nebulized ☐ once ☐ twice a day
☐ Singulair® (Montelukast) ☐ 4, ☐ 5, ☐ 10 mg	1 tablet daily
☐ Other	
☐ None	

Remember to rinse your mouth after taking inhaled medicine.

If exercise triggers your asthma, take____________________ ____ puff(s) ____minutes before exercise.

CAUTION (Yellow Zone)

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

You have ***any*** of these:
- Cough
- Mild wheeze
- Tight chest
- Coughing at night
- Other:__________

If quick-relief medicine does not help within 15-20 minutes or has been used more than 2 times and symptoms persist, call your doctor or go to the emergency room.

And/or Peak flow from______ to______

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	2 puffs every 4 hours as needed
☐ Xopenex®	2 puffs every 4 hours as needed
☐ Albuterol ☐ 1.25, ☐ 2.5 mg	1 unit nebulized every 4 hours as needed
☐ Duoneb®	1 unit nebulized every 4 hours as needed
☐ Xopenex® (Levalbuterol) ☐ 0.31, ☐ 0.63, ☐ 1.25 mg	1 unit nebulized every 4 hours as needed
☐ Combivent Respimat®	1 inhalation 4 times a day
☐ Increase the dose of, or add:	
☐ Other	

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

EMERGENCY (Red Zone)

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

Your asthma is getting worse fast:
- Quick-relief medicine did not help within 15-20 minutes
- Breathing is hard or fast
- Nose opens wide • Ribs show
- Trouble walking and talking
- Lips blue • Fingernails blue
- Other:__________

And/or Peak flow below __________

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	4 puffs every 20 minutes
☐ Xopenex®	4 puffs every 20 minutes
☐ Albuterol ☐ 1.25, ☐ 2.5 mg	1 unit nebulized every 20 minutes
☐ Duoneb®	1 unit nebulized every 20 minutes
☐ Xopenex® (Levalbuterol) ☐ 0.31, ☐ 0.63, ☐ 1.25 mg	1 unit nebulized every 20 minutes
☐ Combivent Respimat®	1 inhalation 4 times a day
☐ Other	

Triggers

Check all items that trigger patient's asthma:

- ❑ Colds/flu
- ❑ Exercise
- ❑ Allergens
  - ❍ Dust Mites, dust, stuffed animals, carpet
  - ❍ Pollen - trees, grass, weeds
  - ❍ Mold
  - ❍ Pets - animal dander
  - ❍ Pests - rodents, cockroaches
- ❑ Odors (Irritants)
  - ❍ Cigarette smoke & second hand smoke
  - ❍ Perfumes, cleaning products, scented products
  - ❍ Smoke from burning wood, inside or outside
- ❑ Weather
  - ❍ Sudden temperature change
  - ❍ Extreme weather - hot and cold
  - ❍ Ozone alert days
- ❑ Foods:
  - ❍ __________
  - ❍ __________
  - ❍ __________
- ❑ Other:
  - ❍ __________
  - ❍ __________
  - ❍ __________

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

Disclaimers: [illegible]

[illegible]

REVISED AUGUST 2014

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Permission to Self-administer Medication:

☐ This student is capable and has been instructed in the proper method of self-administering of the non-nebulized inhaled medications named above in accordance with NJ Law.

☐ This student is not approved to self-medicate.

PHYSICIAN/APN/PA SIGNATURE____________________ DATE__________

Physician's Orders

PARENT/GUARDIAN SIGNATURE____________________

PHYSICIAN STAMP

Save

Print

Print Medicines Only

Make a copy for parent and for physician file, send original to school nurse or child care provider.

The Calais School

Doctor *(if applicable)*

Limited Gym Activity Form

Below is a general idea of units in physical education class. Typically there is about one week of skill building and two weeks of game play per unit.

Please check the physical activities that _____ may not participate in due to a diagnosis of _____from _____ to _____.

____ Soccer
____ Fitness
____ Flag Football
____ Team Handball
____ Badminton
____ Basketball
____ Dance
____ Volleyball
____ Hockey
____ Softball
____ Frisbee
____ Lacrosse
____ Relay Races
____ Misc. team activities (kickball, capture the flag, etc)
____ Swimming (extended school year only)
____ Trampoline (extended school year only)

Please note any other restrictions to this student's physical education:

_____
_____
_____
_____

_____ _____

Physician's Signature & Physician's Stamp *Date*

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Doctor *(New Students Only)*

APPENDIX H

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: *American Academy of Pediatrics, New Jersey Chapter*
New Jersey Academy of Family Physicians
New Jersey Department of Health

SECTION I - TO BE COMPLETED BY PARENT(S)			
Child's Name *(Last)* *(First)*		Gender ☐ Male ☐ Female	Date of Birth / /
Does Child Have Health Insurance? ☐Yes ☐No	If Yes, Name of Child's Health Insurance Carrier		
Parent/Guardian Name	Home Telephone Number ( ) -	Work Telephone/Cell Phone Number ( ) -	
Parent/Guardian Name	Home Telephone Number ( ) -	Work Telephone/Cell Phone Number ( ) -	
I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.			
Signature/Date		This form may be released to WIC. ☐Yes ☐No	

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER		
Date of Physical Examination:	Results of physical examination normal? ☐Yes ☐No	
Abnormalities Noted:	Weight *(must be taken within 30 days for WIC)*	
	Height *(must be taken within 30 days for WIC)*	
	Head Circumference *(if <2 Years)*	
	Blood Pressure *(if ≥3 Years)*	

IMMUNIZATIONS	☐ Immunization Record Attached ☐ Date Next Immunization Due: _____

MEDICAL CONDITIONS		
Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐ None ☐ Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	☐ None ☐ Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☐ None ☐ Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐ None ☐ Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☐ None ☐ Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☐ None ☐ Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☐ None ☐ Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: ☐ Capillary ☐ Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

☐ ***I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.***

Name of Health Care Provider (Print)	Health Care Provider Stamp:
Signature/Date	

CH-14 OCT 17 Distribution: Original-Child Care Provider Copy-Parent/Guardian Copy-Health Care Provider

Making a difference… one child at a time.

Instructions for Completing the Universal Child Health Record (CH-14)

Section 1 - Parent

Please have the parent/guardian complete the top section and sign the consent for the child care provider/school nurse to discuss any information on this form with the health care provider.

The WIC box needs to be checked only if this form is being sent to the WIC office. WIC is a supplemental nutrition program for Women, Infants and Children that provides nutritious foods, nutrition counseling, health care referrals and breast feeding support to income eligible families. For more information about WIC in your area call 1-800-328-3838.

Section 2 - Health Care Provider

1. Please enter the date of the physical exam that is being used to complete the form. Note significant abnormalities especially if the child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing etc.)
   - **Weight** - Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within the last 30 days.
   - **Height** - Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within the last 30 days.
   - **Head Circumference** - Only enter if the child is less than 2 years.
   - **Blood Pressure** - Only enter if the child is 3 years or older.
2. **Immunization** - A copy of an immunization record may be copied and attached. If you need a blank form on which to enter the immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Department of Health, Vaccine Preventable Diseases Program at 609-826-4860. The Immunization record must be attached for the form to be valid.
   - "Date next immunization is due" is optional but helps child care providers to assure that children in their care are up-to-date with immunizations.
3. **Medical Conditions -** Please list any ongoing medical conditions that might impact the child's health and well being in the child care or school setting.
   a. Note any significant medical conditions or major surgical history. **If the child has a complex medical condition, a special care plan should be completed and attached for any of the medical issue blocks that follow.** A generic care plan (CH-15) can be downloaded at www.nj.gov/health/forms/ch-15.dot or pdf. Hard copies of the CH-15 can be requested from the Division of Family Health Services at 609-292-5666.
   b. **Medications -** List any ongoing medications. Include any medications given at home if they might impact the child's health while in child care (seizure, cardiac or asthma medications, etc.). Short-term medications such as antibiotics do not need to be listed on this form. Long-term antibiotics such as antibiotics for urinary tract infections or sickle cell prophylaxis should be included.

   PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigger medication administration. *Please be specific about what over-the-counter (OTC) medications you recommend, and include information for the parent and child care provider as to dosage, route, frequency, and possible side effects. Many child care providers may require separate permissions slips for prescription and OTC medications.*

   c. **Limitations to physical activity -** Please be as specific as possible and include dates of limitation as appropriate. Any limitation to field trips should be noted. Note any special considerations such as avoiding sun exposure or exposure to allergens. Potential severe reaction to insect stings should be noted. Special considerations such as back-only sleeping for infants should be noted.
   d. **Special Equipment** – Enter if the child wears glasses, orthodontic devices, orthotics, or other special equipment. Children with complex equipment needs should have a care plan.
   e. **Allergies/Sensitivities -** Children with life-threatening allergies should have a special care plan. Severe allergic reactions to animals or foods (wheezing etc.) should be noted. Pediatric asthma action plans can be obtained from The Pediatric Asthma Coalition of New Jersey at www.pacnj.org or by phone at 908-687-9340.
   f. **Special Diets** - Any special diet and/or supplements that are medically indicated should be included. Exclusive breastfeeding should be noted.
   g. **Behavioral/Mental Health issues** – Please note any significant behavioral problems or mental health diagnoses such as autism, breath holding, or ADHD.
   h. **Emergency Plans -** May require a special care plan if interventions are complex. Be specific about signs and symptoms to watch for. Use simple language and avoid the use of complex medical terms.
4. **Screening** - This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public heath personnel to track children's health. Please enter the date that the test was performed. Note if the test was abnormal or place an "N" if it was normal.
   - For lead screening state if the blood sample was capillary or venous and the value of the test performed.
   - For PPD enter millimeters of induration, and the date listed should be the date read. If a chest x-ray was done, record results.
   - Scoliosis screenings are done biennially in the public schools beginning at age 10.

   This form may be used for clearance for sports or physical education. As such, please check the box above the signature line and make any appropriate notations in the Limitation to Physical Activities block.
5. Please sign and date the form with the date the form was completed (note the date of the exam, if different)
   - Print the health care provider's name.
   - Stamp with health care site's name, address and phone number.

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Doctor *(HS sports only – stays in Drs office)*

This form should be maintained by the healthcare provider completing the physical exam (medical home). It should not be shared with schools. The medical eligibility form is the only form that should be submitted to a school. The physical exam must be completed by a healthcare provider who is a licensed physician, advanced practice nurse or physician assistant who has completed the Student-Athlete Cardiac Assessment Professional Development module hosted by the New Jersey Department of Education.

■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, non-binary, or another gender): _____

Have you had COVID-19? (check one): ☐ Y ☐ N

Have you been immunized for COVID-19? (check one): ☐ Y ☐ N If yes, have you had: ☐ One shot ☐ Two shots ☐ Three shots ☐ Booster date(s) _____

List past and current medical conditions. _____

Have you ever had surgery? If yes, list all past surgical procedures. _____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU (*CONTINUED*)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		

HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Unsure	Yes	No
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?			
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?			
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?			

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Doctor *(HS sports only – stays in Drs office)*

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		
MEDICAL QUESTIONS	**Yes**	**No**
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle, your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease? **Unsure**		
24. Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (*CONTINUED*)	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		

MENSTRUAL QUESTIONS	N/A	Yes	No
29. Have you ever had a menstrual period?			
30. How old were you when you had your first menstrual period?			
31. When was your most recent menstrual period?			
32. How many periods have you had in the past 12 months?			

Explain "Yes" answers here.

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

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The Calais School

Doctor *(HS sports only – stays in Drs office)*

This form should be maintained by the healthcare provider completing the physical exam (medical home). It should not be shared with schools. The Medical Eligibility Form is the only form that should be submitted to a school.

■ PREPARTICIPATION PHYSICAL EVALUATION

ATHLETES WITH DISABILITIES FORM: SUPPLEMENT TO THE ATHLETE HISTORY

Name:_____ Date of birth: _____

1. Type of disability:		
2. Date of disability:		
3. Classification (if available):		
4. Cause of disability (birth, disease, injury, or other):		
5. List the sports you are playing:		
	Yes	**No**
6. Do you regularly use a brace, an assistive device, or a prosthetic device for daily activities?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed as having a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "Yes" answers here.

_____

_____

_____

Please indicate whether you have ever had any of the following conditions:

	Yes	**No**
Atlantoaxial instability		
Radiographic (x-ray) evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "Yes" answers here.

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

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Doctor *(HS sports only – stays in Drs office)*

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PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

PHYSICIAN REMINDERS

1. Consider additional questions on more-sensitive issues.
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height: Weight:		
BP: / (/) Pulse: Vision: R 20/ L 20/ Corrected: ☐ Y ☐ N		
COVID-19 VACCINE		
Previously received COVID-19 vaccine: ☐ Y ☐ N Administered COVID-19 vaccine at this visit: ☐ Y ☐ N If yes: ☐ First dose ☐ Second dose ☐ Third dose ☐ Booster date(s) _____		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

[a] Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

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The Calais School

Doctor *(HS sports only – Return to School)*

Preparticipation Physical Evaluation Medical Eligibility Form

The Medical Eligibility Form is the only form that should be submitted to school. It should be kept on file with the student's school health record.

Student Athlete's Name _____ Date of Birth _____

Date of Exam _____

- o Medically eligible for all sports without restriction
- o Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of
- o Medically eligible for certain sports
- o Not medically eligible pending further evaluation
- o Not medically eligible for any sports

Recommendations: _____

I have reviewed the history form and examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings- are on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Signature of physician, APN, PA _____ Office stamp (optional)

Address: _____

Name of healthcare professional (print) _____

I certify I have completed the Cardiac Assessment Professional Development Module developed by the New Jersey Department of Education.

Signature of healthcare provider _____

Shared Health Information

Allergies _____

Medications:

Other information: _____

Emergency Contacts: _____

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**This form has been modified to meet the statutes set forth by New Jersey.*

The Calais School

ATTENDANCE POLICY

PLEASE DO NOT FORGET TO CALL THE CALAIS SCHOOL AT

(973) 884-2030

FOR EACH DAY YOUR STUDENT WILL BE ABSENT FROM SCHOOL.

If you know in advance of any days your student will be absent, **please** send a note to the school addressed to your student's homeroom teacher. The teacher will give the information to the Main Office.

Your student's safety is our greatest concern. The Calais School Main Office will call your home or office should you not call or send a note to confirm the whereabouts of your student.

FIVE DAY LETTERS

Based on New Jersey state regulations, The Calais School must send an official notification when a student has been absent for five days, regardless of whether the absence was excused or unexcused. A letter will be mailed to your district case manager when your child has been absent for five days.

The Calais School

WEATHER CLOSING OR DELAY NOTICE

Dear Parents and Guardians,

In the past, inclement winter weather conditions have brought to light the fact that many of our drivers are not aware of the means to find out about our school closings or delays. We realize that this information is essential for you to make alternate arrangements. A decision to close or delay a school opening is made as early as possible, usually the evening before or by 5:30 a.m.

All Calais School closings or delays are broadcast on the following radio, cable TV stations and through the "RealTime" automated phone call system:

RealTime automated phone call system (see attached form)
Calais website: www.thecalaisschool.org
Calais Facebook Page

We hope this information is helpful.

Sincerely,
Theresa Fritzky
Principal