

## Admission Physical Packet Information:

Enclosed please find the Admission Physical Packet required for admission.

- A current physical is required for admission. The **Date of Exam must be after August 10, 2025** to meet admission requirements. Any physical dated before this will be returned.
- This packet also includes the Asthma Treatment Plan, Allergy Emergency Treatment Plan, and Seizure Action Plan. If any of these apply to your child, please follow the directions below:
  - **Inhaler:** If your child uses an inhaler, an additional inhaler form is required. This form must be completed and signed by your child's doctor. Parent and doctor signatures are required at the bottom of the form. Please return this form with the physical.
  - **EpiPen:** If your child has an EpiPen, an additional form is required. The doctor must complete and sign the form. A parent signature is also required on the reverse side under the "May Self-Administer" section and in the student information section. Return this completed form with the physical packet. Please bring the EpiPen and Benadryl to school on the first day.

The completed **original** physical form packet (the only acceptable version) and any required medication forms must be returned to SJV **by the first week of May 2026**. No faxes, copies, or alternate forms will be accepted. Please make a copy for your records.

**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 \_\_\_\_\_

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

# Saint John Vianney High School



## PHYSICIAN'S ORDERS FOR ALLERGY EMERGENCY TREATMENT

Student's name \_\_\_\_\_ Birth date \_\_\_\_\_ Grade \_\_\_\_\_

The above student is allergic to: \_\_\_\_\_

Previous episode of anaphylaxis  Yes  No

### MEDICATIONS

ANTIHISTAMINE: Name \_\_\_\_\_ Dose \_\_\_\_\_

Give antihistamine for the following checked symptoms:

- Contact with allergen, but no symptoms
- Skin – hives, itchy rash, extremity swelling
- Lips – itching, tingling, burning, or swelling of lips
- Head/neck – swelling of tongue, mouth, or throat, hoarseness, hacking cough, tightening of throat
- Gut – abdominal cramps, nausea, vomiting, diarrhea
- Lungs – repetitive cough, wheezing, shortness of breath
- Heart – thready pulse, low blood pressure, fainting, pale or bluish skin
- Other \_\_\_\_\_

EPINEPHRINE:  EpiPen  EpiPen Jr.  Other \_\_\_\_\_

Give Epinephrine for the following checked symptoms:

- Contact with allergen, but no symptoms
- Skin – hives, itchy rash, extremity swelling
- Lips – itching, tingling, burning, or swelling of lips
- Head/neck – swelling of tongue, mouth, or throat, hoarseness, hacking cough, tightening of throat
- Gut – abdominal cramps, nausea, vomiting, diarrhea
- Lungs – repetitive cough, wheezing, shortness of breath
- Heart – thready pulse, low blood pressure, fainting, pale or bluish skin
- Other \_\_\_\_\_

### Choose one administration order:

Give Antihistamine only  Give epinephrine only  \*Delegate will be assigned

Give Antihistamine & Epinephrine at same time  \*Delegate will be assigned

Give Antihistamine first, observe for further symptoms and give epinephrine PRN

**\*Please note- in the absence of a school nurse, a trained delegate will give epinephrine and any antihistamine order will be disregarded**

This student has been trained and is capable of self-administration of the following medication(s) named above.  Epinephrine – single dose unit  Epinephrine & antihistamine – single dose units

\*Under NJ state law, orders for antihistamine alone cannot be self-administered

This student is not capable of self-administration of the medications named above.

Physician's signature \_\_\_\_\_

Phone number \_\_\_\_\_

Date \_\_\_\_\_

Stamp \_\_\_\_\_

D

Parents/Guardians

A current single dose Epinephrine auto-injector must be provided to the school for your child's use. All Antihistamines and Epinephrine must be brought to school by an adult and be provided in the original container.

Parents, Select ONLY ONE (1) OR TWO (2) to sign and date:

(1) May Self-Administer

I verify that my child \_\_\_\_\_ has a potentially life threatening illness and has been instructed in self-administration of the prescribed medication in a life threatening situation. I hereby give permission for my child to self-administer prescribed medication. I further acknowledge that \_\_\_\_\_ School shall incur no liability as a result of any injury arising from the self-administration of medication by my child. If procedures specified by NJ law and School policy are followed, I shall indemnify and hold harmless the School and its employees or agents against any claims arising out of self-administration of medication by my child.

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

\_\_\_\_\_  
Date

OR

(2) May Not Self-Administer

I verify that my child \_\_\_\_\_ has a potentially life threatening illness and is unable to self-administer the prescribed medication in a life threatening situation. I hereby request the school nurse or delegate (if applicable) to administer the prescribed medication to my child. I further acknowledge that the School shall incur no liability as a result of any injury arising from administration of the medication to my child. If procedures specified by NJ law and School Policy are followed, I shall indemnify and hold harmless the School and its employees or agents against any claims arising out of administration of medication to my child.

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

\_\_\_\_\_  
Date

Please sign below:

I understand that under NJ state law (P.L. 1997 c368(c.18a:40-12.5)), a trained delegate will be assigned to administer epinephrine to my child in the absence of a school nurse. In the absence of a school nurse, any antihistamine order will be disregarded and epinephrine will be administered by a trained delegate. The Trained Delegates are:

1. Katharine Brattley A.C. 3. Cheyenne Bennett

2. Gabrielle Tantiello 4. \_\_\_\_\_

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

## ASSUMPTION OF RISK, WAIVER, AND RELEASE OF LIABILITY

I \_\_\_\_\_, the parent/legal guardian of \_\_\_\_\_ ("the Minor Student") do hereby acknowledge and agree to the following with regard to the activities listed below:

1. Authority. The undersigned represents and agrees that he/she is the parent or legal guardian of the Minor Student; that he/she has full legal authority to act on behalf of the Minor Student; and that he/she agrees to assume the risk(s) of the Minor Student's attendance at activities at, with, or on behalf of, St. John Vianney High School ("SJV") and its employees, agents, and/or volunteers, including but not limited to activities involving food.
2. Assumption of Risk. The undersigned knowingly and freely acknowledges that SJV is not a food allergy-free school, including but not limited to seafood and peanut allergies. Accordingly, the undersigned knowingly and freely assumes all risks associated with food allergies, including but not limited to: cross contamination; mislabeling of food products; the Minor Student choosing the incorrect food product; change of ingredients by a third-party food vendor; misjudgment by the Minor Student or others, or any other risks associated with food allergies. The undersigned knowingly and freely assumes full responsibility for all potential risks associated with food allergies, even if such risks arise from the negligence of SJV, its agents, directors, officers, employees, and/or volunteers, including but not limited to Steven DiMezza, President, The Diocese of Trenton, and, the Most Reverend David M. O'Connell, CM, Bishop of Trenton.
3. Indemnification. The undersigned agrees to indemnify, defend, and hold harmless SJV, its employees, agents, directors, officers, employees, and/or volunteers including but not limited to Steven DiMezza, President, The Diocese of Trenton, and, the Most Reverend David M. O'Connell, CM, Bishop of Trenton (the "Indemnitees") from and against any and all claims, demands, and causes of action, or possible causes of action, arising out of or related to any loss, damage, or injury that may be sustained by the Minor Student related to any food allergies, known or unknown. Likewise, the undersigned agrees to waive any and all personal claims, demands, and causes of action, or possible causes of action related to any food allergies, known or unknown, against the Indemnitees.
4. WAIVER AND RELEASE. The undersigned, on behalf of himself or herself, and the Minor Student, as well as his/her heirs, assigns, personal representatives and next of kin, **HEREBY RELEASES AND HOLDS HARMLESS SJV, its agents, directors, officers, employees, and/or volunteers including but not limited to Steven DiMezza, President, The Diocese of Trenton, and, the Most Reverend David M. O'Connell, CM, Bishop of Trenton (collectively the "Releasees") WITH RESPECT TO ANY AND ALL INJURY, ILLNESS, DISABILITY, DEATH, or loss or damage to person or property, WHETHER ARISING FROM THE NEGLIGENCE OF THE RELEASEES OR OTHERWISE.**
5. Governing Law. If any section, paragraph, clause or provision of this assumption of the risk, waiver of liability and release agreement shall for any reason be held to be invalid or

unenforceable, the invalidity or unenforceability of such section, paragraph, clause or provision shall not affect any of the remaining provisions of this assumption of risk, waiver of liability and release agreement, the intent being that the same are severable. This Agreement shall be construed in accordance with and governed by the laws of the State of New Jersey without regard to conflicts of law principles.

**I HAVE READ THIS ASSUMPTION OF RISK, WAIVER, AND RELEASE OF LIABILITY, FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY AGREEING TO IT ON MY OWN BEHALF AND/OR ON BEHALF OF MINOR STUDENT IDENTIFIED BELOW, AND I SIGN IT FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT.**

MINOR STUDENT

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

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

Date of Birth: \_\_\_\_\_

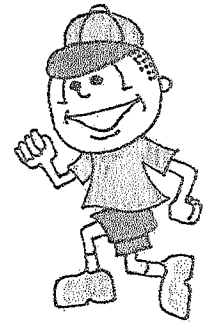
Signature: \_\_\_\_\_

Date: \_\_\_\_\_

PARENT / LEGAL GUARDIAN:



# 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.

- 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
- 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
- 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
- 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

# 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 \_\_\_\_\_