Asthma Treatment Plan – Student

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

PACNJ Pediatric/Adult Asthma Coalition

Sponsored by American Lung Association. in New Jersey

NJ Health New Jersey Department of Health

(Please Print)

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

HEALTHY (Green Zone)

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

And/or Peak flow above _____

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

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ 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 or ☐ twice a day
☐ Flovent® Diskus® ☐ 50 ☐ 100 ☐ 250	1 inhalation twice a day
☐ Pulmicort Flexhaler® ☐ 90, ☐ 180	☐ 1, ☐ 2 inhalations ☐ once or ☐ twice a day
☐ Pulmicort Respules® (Budesonide) ☐ 0.25, ☐ 0.5, ☐ 1.0	1 unit nebulized ☐ once or ☐ 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)

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_____

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

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)

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 _____

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

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ 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.

REVISED MAY 2017

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

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

Asthma Treatment Plan – Student
Parent Instructions

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

1. **Parents/Guardians:** *Before taking this form to your Health Care Provider,* complete the top left section with:
   - Child's name
   - Child's 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 _____

PACNJ Pediatric/Adult Asthma Coalition

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Sponsored by

AMERICAN LUNG ASSOCIATION. IN NEW JERSEY

2022-2023 MANDATORY MEDICATION FORM

ALL MEDICATION (prescription and OTC, including Tylenol and Advil) must be accompanied by written permission from BOTH the PARENT and PHYSICIAN.

- **Prescription medication** must be delivered to the nurse by the parent in the original container, labeled with the student's name, medication, dosage and physician's name.
- **OTC medication** must be delivered to school by the parent in the original sealed container and labeled with the student's name.
- **Written permission** of the student's physician and parent/guardian are required, including the student's name, purpose of the medication, the time (or circumstance) at which the medication should be administered, and the length of time for which the medication is prescribed.

Only those medications which are medically necessary during school hours for a student's wellbeing should be sent to school.

NOTE: THE FIRST DOSE OF ANY MEDICATION MAY *NOT* BE GIVEN AT SCHOOL.

NAME OF STUDENT _____ DOB _____

NAME OF MEDICATION _____

DOSAGE _____

TIME TO BE GIVEN _____

REASON FOR MEDICATION _____

MEDICATION TO BE GIVEN FROM _____ (DATE) TO _____ (DATE)

HOW IT IS TAKEN _____
EXAMPLE: BY MOUTH, INHALER, WITH FOOD, CRUSHED, ETC.

ADDITIONAL COMMENTS _____

_____ PARENT SIGNATURE/DATE

_____ PHYSICIAN SIGNATURE/DATE

_____ TELEPHONE NUMBER

_____ TELEPHONE NUMBER

ADDITIONAL MEDICATIONS

NAME OF STUDENT _____ DOB _____

NAME OF MEDICATION _____

DOSAGE _____

TIME TO BE GIVEN _____

REASON FOR MEDICATION _____

MEDICATION TO BE GIVEN FROM _____ TO _____
DATE DATE

HOW IT IS TAKEN _____
EXAMPLE: BY MOUTH, INHALER, WITH FOOD, CRUSHED, ETC.

ADDITIONAL COMMENTS _____

NAME OF STUDENT _____ DOB _____

NAME OF MEDICATION _____

DOSAGE _____

TIME TO BE GIVEN _____

REASON FOR MEDICATION _____

MEDICATION TO BE GIVEN FROM _____ TO _____
DATE DATE

HOW IT IS TAKEN _____
EXAMPLE: BY MOUTH, INHALER, WITH FOOD, CRUSHED, ETC.

ADDITIONAL COMMENTS _____

****

_____ _____
PARENT SIGNATURE/DATE PHYSICIAN SIGNATURE/DATE

_____ _____
TELEPHONE NUMBER TELEPHONE NUMBER

PERMISSION TO SHARE INFORMATION
2022-2023

As you are aware, everyday each of our students has contact with a variety of staff members; teachers, bus drivers, therapists, assistants, cafeteria workers, and student interns. While your child is in the care of these people, it is important that they are aware of any information that would require special considerations for his or her health and safety.

To comply with privacy laws, I am requesting your permission to share personal information about your child. This would consist of only that information deemed necessary to protect the well-being of your child. Examples of information that could be shared about your child may include; known allergies, special diets or food restriction, and a history of seizures. This may be done in the form of a printed list or verbal contact with those people who will be working closely with your child. If you have specific questions regarding your child, please call me at school. As always, please feel comfortable knowing that any information you do not want shared with anyone will be kept confidential. Thank you.

PLEASE COMPLETE, SIGN BELOW AND RETURN THIS FORM TO YOUR CHILD'S SCHOOL

Child's Name: _____

_____ **Yes**, I give permission for personal information about my child to be shared with other staff members if it will protect his/her health and safety.

_____ **No**, I do not give permission for personal information about my child to be shared with other staff members if it will protect his/her health and safety.

_____ _____

Parent/Guardian Signature Date

2022-2023 PHYSICIAN/PARENT CERTIFICATION FOR STUDENT'S SELF-ADMINISTRATION OF MEDICATION

CERTIFICATION TO BE COMPLETED BY PHYSICIAN

STUDENT NAME: _____

DIAGNOSIS: _____

NAME OF MEDICATION: _____

DOSAGE: _____

TIME AND CIRCUMSTANCES OF ADMINISTRATION: _____

POSSIBLE SIDE EFFECTS: _____

I certify that _____ has a potentially life threatening illness
(Student)
which requires the use of _____. I further certify that
(Medication)
_____ is capable and has been instructed in the proper method of
(Student)
self-administration of _____
(Medication)

_____ _____
Signature of Physician Date

PHYSICIAN NAME: _____ TELEPHONE #: _____

****

CERTIFICATION TO BE COMPLETED BY PARENT

I hereby authorize my son/daughter _____ to self-administer (Name of Medication) _____ in accordance with special guidelines.

I acknowledge that the school shall incur no liability as a result of any injury arising from the self-administration of medication by (student name) _____.

I shall indemnify and hold harmless the school, its employees and agents against any and all claims arising out of the self-administration of (medication) _____ by (student name) _____.

_____ _____
Parent/Guardian Signature Date

SELF-ADMINISTRATION OF MEDICATION IN SCHOOL

Under N.J.S.A. 18A:40-12.3, self-administration of medication by a pupil for asthma or other potentially life threatening illness is allowed under guidelines established by the school and provided that the statutory requirements set forth in this form are complied with.

Any permission for the self-administration of medication is effective for this school year only.

N.J.S.A. 18A:40-12.3 PROVIDES THAT THE SCHOOL SHALL INCUR NO LIABILITY AS A RESULT OF ANY INJURY ARISING FROM THE SELF-ADMINISTRATION OF MEDICATION BY A STUDENT.

Rev: 4/2015

Asthma History Form

School year:_____

Student:_____ Grade:_____ Date of Birth:_____

Healthcare Provider:_____ Phone number:_____

History

1. How old was your child when diagnosed with asthma?

2. Describe the symptoms your child has with a typical asthma episode (wheeze, cough, shortness of breath, etc.)

3. How does your child describe these symptoms?

4. How frequently does your child experience each type of symptom?

	Times/Week	Times/Month	Times/Year	Never
Mild (resolves quickly with rest or medication)	_____	_____	_____	_____
Moderate (requires a doctor visit to get things under control)	_____	_____	_____	_____
Severe (requires a visit to the Emergency Room)	_____	_____	_____	_____

5. Has your child ever been hospitalized for asthma? _____ No _____ Yes
   If yes, please explain:

6. Identify the things that may trigger your child to have an asthma episode. Check all that apply.

- ☐ Exercise
- ☐ respiratory infections
- ☐ cold temperature
- ☐ hot temperatures
- ☐ change in temperature
- ☐ strong odors/fumes
- ☐ chalk dust
- ☐ sitting on a carpet
- ☐ pollen
- ☐ mold
- ☐ Animals
- ☐ Dust
- ☐ foods
- ☐ Ozone alert days
- ☐ Other _____

Comments:

Current Asthma Management

7. How does your child understand his/her asthma and what he/she should do to manage it?

8. Please list the medications your child takes routinely, the dosage, how often taken, when and under what circumstances additional doses may be given.

Medication	Dosage	How Often	Additional Doses

9. Does your child suffer side effects from the medication? _____ No _____ Yes
If yes, please list medication and specific side effects.

Medication	Side Effects

SCHOOL ASTHMA ACTION PLAN/ASTHMA MEDICATIONS

Students with asthma must submit this Asthma-Student Health History (completed), an Asthma Treatment Plan (completed and signed by the student's doctor and signed by the parent on both sides), and the prescribed medication to the school nurse.

The district is required to keep an Asthma Action Plan on file for all students who require an asthma inhaler or nebulized medication here at school.

An Asthma Action Plan includes information about medications & asthma triggers, which is important information for proper asthma management at both home and school.

All medications must be brought in by a parent and kept in the health office unless approval has been given by the health office and the student's physician for a student to self-carry an inhaler. If your child has permission to self-carry an inhaler, please send an extra one to be kept in the health office in the event your child forgets to bring it to school.

All medication forms (including asthma and allergy forms) are required to be updated and resubmitted each school year at the beginning of the year. Failure to do so may compromise our ability to safely care for your child.

If you have any questions, please contact the school nurse- Susan Peluso RN at susan@thearrowacademy.org

Parent/Guardian signature:_____ Date:_____

90 Whippany Rd, Whippany, NJ, 07981
Health Office
Phone: 973-888-2083

MEDICATION PROTOCOL

Medication will be given in school only when a pupil's health and continuing attendance in school requires it and it is administered in accordance with the medication policy. No student is to carry medication to and from school. If it is necessary that medication be taken during school hours, the following is required:

1. All medication, prescription and over the counter, must be accompanied by a written request from a physician. These orders must include the diagnosis or type of illness, name of drug, dosage, time of administration, length of time for which it is required, and side effects of medication. Written orders must be renewed on an annual basis at the beginning of each school year.
2. A Mandatory Medication Form, Asthma Action Plan and/or Allergy Emergency Treatment form must be completed by the primary care provider and signed by parent/guardian.
3. Medication is to be in the correct prescription bottle, labeled with the name of the child, current dosage, date of prescription, and name of prescribing primary care provider
4. Parents must bring all medications to the Health Office. Students should never carry medication to school unless the doctor specifically orders that the student may carry and self-administer emergency epinephrine or inhaler.
5. Self-administration of medication for asthma or other potentially life-threatening illnesses require additional doctor and parent signatures on the form.
6. Non Prescription medications (i.e. Ibuprofen, Tylenol) may only be administered when a Mandatory Medication Form is completed by the primary care provider and signed by a parent. These medications must come in the original container.
7. According to NJ Law, school nurses cannot administer alternative remedies such as herbal medications and essential oils.
8. No parent's or primary care provider's phone instructions can be accepted.
9. Parents must pick up the medication from the Nurse in June on the last day of school. No medications will be sent home with a student. Medications will be properly disposed of if parents do not pick up the medication on the last day of school.