My Asthma Action Plan
For Home and School

Name: ______________________________ DOB: ____ / ____ / ______

Severity Classification: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Asthma Triggers (list): ______________________________

Peak Flow Meter Personal Best: __________

Green Zone: Doing Well

Symptoms: Breathing is good – No cough or wheeze – Can work and play – Sleeps well at night

Peak Flow Meter __________ (more than 80% of personal best)

Flu Vaccine—Date received: __________ **Next flu vaccine due:** __________ **COVID19 vaccine—Date received:** __________

Control Medicine(s) Medicine	How much to take	When and how often to take it	Take at
__________	__________	__________	☐ Home ☐ School
__________	__________	__________	☐ Home ☐ School

Physical Activity ☐ Use Albuterol/Levalbuterol _____ puffs, 15 minutes before activity ☐ with all activity ☐ when you feel you need it

Yellow Zone: Caution

Symptoms: Some problems breathing – Cough, wheeze, or tight chest – Problems working or playing – Wake at night

Peak Flow Meter ________ to ________ (between 50% and 79% of personal best)

Quick-relief Medicine(s) ☐ Albuterol/Levalbuterol _____ puffs, every 20 minutes for up to 4 hours as needed

Control Medicine(s) ☐ Continue Green Zone medicines

☐ Add __________ ☐ Change to __________

You should feel better within 20-60 minutes of the quick-relief treatment. If you are getting worse or are in the Yellow Zone for more than 24 hours, THEN follow the instructions in the RED ZONE and call the doctor right away!

Red Zone: Get Help Now!

Symptoms: Lots of problems breathing – Cannot work or play – Getting worse instead of better – Medicine is not helping

Peak Flow Meter __________ (less than 50% of personal best)

Take Quick-relief Medicine NOW! ☐ Albuterol/Levalbuterol _____ puffs, __________ (how frequently)

Call 911 immediately if the following danger signs are present:
- Trouble walking/talking due to shortness of breath
- Lips or fingernails are blue
- Still in the red zone after 15 minutes

School Staff: Follow the Yellow and Red Zone instructions for the quick-relief medicines according to asthma symptoms.
The only control medicines to be administered in the school are those listed in the Green Zone with a check mark next to "Take at School".

☐ Both the Healthcare Provider and the Parent/Guardian feel that the child has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

Healthcare Provider

Name __________ Date __________ Phone (____) ____ - ______ Signature __________

Parent/Guardian

☐ I give permission for the medicines listed in the action plan to be administered in school by the nurse or other school staff as appropriate.

☐ I consent to communication between the prescribing health care provider or clinic, the school nurse, the school medical advisor and school-based health clinic providers necessary for asthma management and administration of this medicine.

Name __________ Date __________ Phone (____) ____ - ______ Signature __________

School Nurse

☐ The student has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

Name __________ Date __________ Phone (____) ____ - ______ Signature __________

Please send a signed copy back to the provider listed above.

MDI, DPI vs. Neb Inhalation Technique

Proper inhalation technique is important when using these medications.

Scan the QR Code to Access How-To Videos

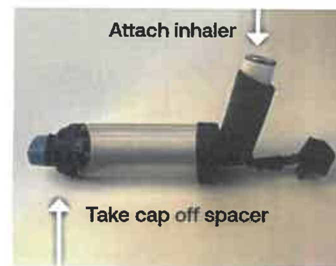
Resources for Asthma

- **Asthma Care Quick Reference**
  https://www.nhlbi.nih.gov/files/docs/guidelines/asthma_qrg.pdf
- **American Lung Association**
  www.lung.org/asthma

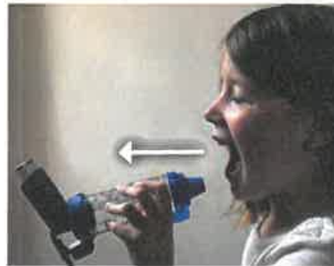
How to use your inhaler and spacer

1. Take the cap off the inhaler

2. Shake the inhaler for 5 seconds



3. Attach to spacer and take cap off spacer



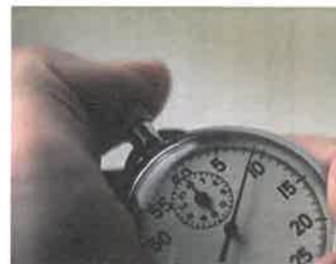
4. Breathe **OUT** all the way

5. Close lips around mouthpiece

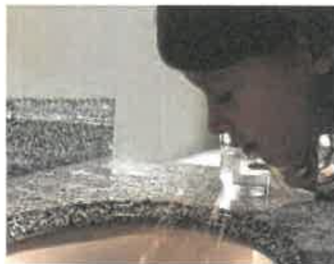
6. Press down here

7. Breathe in **SLOWLY, DEEPLY**

8. Hold your breath for 10 seconds if you can. Then breathe out slowly.



If you need another puff of medicine, wait 1 minute then repeat steps 5-9.



9. Rinse with water and **SPIT OUT**

For more asthma videos, handouts, tutorials and resources, visit **Lung.org/asthma.**

You can also connect with a respiratory therapist for one-on-one, free support the American Lung Association's Lung HelpLine at **1-800-LUNGUSA.**

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2023-2024 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__________________ 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

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____

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PARENT SIGNATURE/DATE PHYSICIAN SIGNATURE/DATE

TELEPHONE NUMBER TELEPHONE NUMBER

PERMISSION TO SHARE INFORMATION 2023-2024

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

2023-2024 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 #: ______________

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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.

Health Office
90 Whippany Rd, Whippany, NJ, 07981
(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.

Asthma History Form

School year:________

Student:______________________________ Grade:______ Date of Birth:__________

Physician:______________________________ Phone number:____________________

A.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:

B.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:___________