Saint Joseph School
305 Elm Street
Oradell, NJ 07649
201-261-1860

June 2017

Dear Parent/Guardian

Each year it is necessary to renew your child's order for medication given in school. Enclosed, please find the required forms for your health care practitioner to fill out with specific instructions. This form should be returned on the first day of school in September along with the medication. As per state law, no medication can be given without a proper doctor's order and students are NOT permitted to carry medications on them without a specific doctor's order.

New Jersey law requires students authorized to use asthma medication shall have an **Asthma Treatment Plan** prepared by the student's health care practitioner on file. For students to carry their inhaler your health care professional must check off the approval at the bottom of the form.

All students requiring Epinephrine for life threatening allergies must complete the **Physician's Order for Allergy Emergency Treatment** form. For students to carry their EpiPen your health care practioner must check off their approval at the bottom of the form.
Parents of students with food allergies are encouraged to provide a snack box to be kept in the classroom in the event of an unexpected party in the classroom.

Please be sure to sign the parent section on the form before returning it to school.
If you have any questions, please feel free to contact me.

Thanking you in advance,

Carol Leibowitz RN

Carol Leibowitz, RN
School Nurse

Parents/Guardian

This permission is for emergency treatment for one school year only. Should permission be necessary in the future, a new form will need to be submitted.

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.

Select one to sign and date

1. 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 the School District 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 District policy are followed, I shall indemnify and hold harmless the School District and its employees or agents against any claims arising out of self administration of medication by my child.

_____ _____
Signature of Parent/Guardian Date

2. 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 District 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 are followed, I shall indemnify and hold harmless the school district and it's employees or agents against any claims arising out of administration of medication to my child.

_____ _____
Signature of Parent/Guardian Date

Please Sign

I understand that under N J Law, **a trained delegate will be assigned to administer** epinephrine to my child **in the absence of a school nurse.** Antihistamines may not be given by a delegate. In the absence of a school nurse, any antihistamine order will be disregarded and epinephrine will be administered by a trained delegate.

_____ _____
Signature of Parent/Guardian Date

_____
Signature of School Nurse Date

TWO-SIDED FORM

PHYSICIAN'S ORDERS FOR ALLERGY EMERGENCY TREATMENT

Student's Name_____ Birth Date _____ Grade/Teacher_____

The above student is allergic to: _____

☐ Ingestion ☐ Contact ☐ Inhalation

Previous episode of anaphylaxis ☐ Yes ☐ No
Asthmatic ☐ Yes ☐ No

MEDICATIONS

ANTIHISTAMINE: Medication _____ Dose _____

Give antihistamine for the following checked symptoms:
☐ Contact with allergen, with or without symptoms
☐ Skin – hives, itchy rash, extremity swelling
☐ Lips – itching, tingling, burning, or swelling of lips
☐ Other _____

EPINEPHRINE: Medication _____ Dose _____

Give epinephrine for the following checked symptoms:
☐ Contact with allergen, with or without 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 _____

AFTER GIVING EPINEPHRINE, 911 AND THE PARENT/GUARDIAN WILL BE CALLED.

OTHER INSTRUCTIONS _____

Note: NJ State Law (P.L.2007, CHAPTER 57) requires every student with an EpiPen order to have a delegate assigned to him/her unless the HCP and/or parent/guardian feel(s) that it is not indicated. Please indicate your preference:

☐ Delegate required ☐ Delegate **NOT** required

PLEASE NOTE: DELEGATES ARE NOT PERMITTED TO ADMINISTER AN ANTIHISTAMINE.

If the nurse is not available, do you want the antihistamine order to be omitted and have the delegate administer epinephrine as indicated above? ☐ YES ☐ NO

This student has been trained and is authorized to self-administer and carry the following medication(s).
☐ epinephrine – single dose unit ☐ antihistamine – single dose unit

☐ This student is not authorized to self-administer the medication(s) named above.

Physician's Signature _____ Phone # _____

Date_____

Physician's Stamp _____

OVER

Asthma Treatment Plan – Student

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

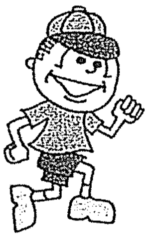
The Pediatric/Adult Asthma Coalition of New Jersey
"Your Pathway to Asthma Control"
PACNJ approved Plan available at www.pacnj.org
Sponsored by AMERICAN LUNG ASSOCIATION IN NEW JERSEY
NJ Health New Jersey Department of Health

(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

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	

And/or Peak flow above ________

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.

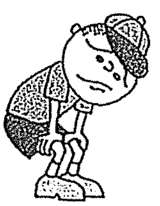
And/or Peak flow from______ to______

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.

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

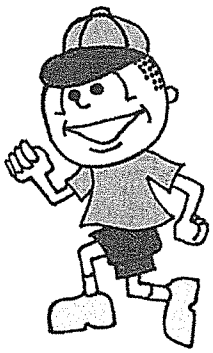
PARENT/GUARDIAN SIGNATURE______________________

PHYSICIAN STAMP

REVISED AUGUST 2014

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 _____

The Pediatric/Adult Asthma Coalition of New Jersey
"Your Pathway to Asthma Control"
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IN NEW JERSEY