Dear Parent/Guardian:

The state law requires that any child using an inhaler must have an “Asthma Treatment Plan” and a “self-medication form” on file at school. In order for us to provide the best care for your child, please complete the attached forms and return them to the school nurse prior to the start of school.

Please note that the first page contains instructions and a part for the parent to sign. The second page is the "Asthma Treatment Plan" which is also to be completed and signed by the doctor. The fourth page is the "Medication Contract" which is to be completed and signed by both the parent and the student.

Please be sure that your child carries their inhaler with them either in their backpack or in their pocket. It is especially important to have the inhaler when they have PE. We would be happy to keep a spare inhaler (properly labeled with the child's name and dosage) in the medicine cabinet in our office.

Please notify us if there are any changes during the year. If you have any questions, please feel free to contact us at the appropriate school. The telephone number for the Elementary School is 201-445-6150; the Middle School is 201-891-3663; and the High School is 973-427-0900.

Thank you,

_ECSA School Nurses_
**Asthma Treatment Plan – Student**

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

**Please Print**

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Birth</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**HEALTHY (Green Zone)**

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

**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 ______

**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: ____________________________

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

<table>
<thead>
<tr>
<th>MEDICINE</th>
<th>HOW MUCH to take and HOW OFTEN to take it</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advair® HFA 45, 115, 230</td>
<td>2 puffs twice a day</td>
</tr>
<tr>
<td>Aerospan™</td>
<td>1, 2 puffs twice a day</td>
</tr>
<tr>
<td>Alvesco® 80, 160</td>
<td>1, 2 puffs twice a day</td>
</tr>
<tr>
<td>Flonext® 100, 200</td>
<td>2 puffs twice a day</td>
</tr>
<tr>
<td>Qvar® 40, 80</td>
<td>1, 2 puffs twice a day</td>
</tr>
<tr>
<td>Symbicort® 80, 160</td>
<td>1, 2 puffs twice a day</td>
</tr>
<tr>
<td>Advair Diskus® 100, 250, 500</td>
<td>1 inhalation twice a day</td>
</tr>
<tr>
<td>Asmanex® Twinline® 110, 220</td>
<td>1, 2 inhalations once or twice a day</td>
</tr>
<tr>
<td>Flonext® Diskus® 50, 100, 250</td>
<td>1 inhalation twice a day</td>
</tr>
<tr>
<td>Pulmicort Flexhaler® 90, 180</td>
<td>1, 2 inhalations once or twice a day</td>
</tr>
<tr>
<td>Pulmicort Respules® (Budesonide)</td>
<td>1 unit nebulized once or twice a day</td>
</tr>
<tr>
<td>Singular® (Montelukast)</td>
<td>1 tablet daily</td>
</tr>
<tr>
<td>Other</td>
<td>None</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>MEDICINE</th>
<th>HOW MUCH to take and HOW OFTEN to take it</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albuterol MDI (Pro-air® or Proventil® or Ventolin®)</td>
<td>2 puffs every 4 hours as needed</td>
</tr>
<tr>
<td>Xopenex®</td>
<td>2 puffs every 4 hours as needed</td>
</tr>
<tr>
<td>Albuterol</td>
<td>1.25, 2.5 mg</td>
</tr>
<tr>
<td>Duoneb®</td>
<td>1 unit nebulized every 4 hours as needed</td>
</tr>
<tr>
<td>Xopenex® (Levalbuterol)</td>
<td>0.31, 0.63, 1.25 mg</td>
</tr>
<tr>
<td>Combivent Respcalm®</td>
<td>1 inhalation 4 times a day</td>
</tr>
</tbody>
</table>

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

**Take these medicines NOW and CALL 911.**

**Asthma can be a life-threatening illness. Do not wait!**

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<td>4 puffs every 20 minutes</td>
</tr>
<tr>
<td>Xopenex®</td>
<td>4 puffs every 20 minutes</td>
</tr>
<tr>
<td>Albuterol</td>
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**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 - roents, 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: ____________________________

**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.

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

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 its employees against any claim arising out of the self-adm inistration by the student of the medication prescribed on this form.

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

**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 N.J.-Atlantic (ALMA-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. ALMA-A makes no representations or warranties about the accuracy, reliability, completeness, currency, or content of the content. ALMA-A makes no warranty, representation or guaranty that the information will be uninterrupted or error-free, or that any defects can be corrected. ALMA-A is liable for any damages from using, without limitation, incidental and consequential damages, personal injury/wrongful death, loss of data, or loss of use of your computer equipment or programs, whether or not ALMA-A is advised of the possibility of such damages. ALMA-A and its affiliates are not liable for any claim, whatsoever, caused by your use or misuse of the Asthma Treatment Plan, or of this website. ALMA-A makes no warranties, representations or guaranties about this website, its content, or its completeness, currency or accuracy.

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 #U59EH00049-5. The content is solely the responsibility of the authors and does 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 entirely or in part by the United States Environmental Protection Agency under Agreement XA962-96601-2, the content is not necessarily reflective of 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 professional.
SELF-ADMINISTRATION OF MEDICATION IN SCHOOL

Request for Self-Administration of Prescription Medication

To be completed by Physician (please print)

NAME OF STUDENT:__________________________________   GRADE:______________

DIAGNOSIS:__________________________________________________________________

MEDICATION:________________________________________________________________

DOSAGE:_________________________   FREQUENCY:______________________________

DIRECTIONS:_________________________________________________________________

POSSIBLE SIDE EFFECTS:______________________________________________________

OTHER MEDICATIONS USED AT HOME:________________________________________

*************************************************************

I certify that this student has asthma or another potentially life-threatening illness and is permitted to self-administer the above medication. He/she has been instructed in the proper techniques of self-administration and has demonstrated competence in this technique.

Conditions under which self-administration will take place:

_____ Under Supervision of School Nurse (or designated personnel)

_____ Independently (child has been trained)

Medication should be:

_____ Stored in Nurse’s office   _____ In possession of student

__________________________________________________________________________

Physician’s Name (print)   ____________________________

__________________________________________________________________________

Physician’s Signature   ___________________________________ Phone

******Other side must be filled out and signed by student and parent******

6/5/2014
MEDICATION CONTRACT

Date________________________

Student Name___________________________________________   Grade______________

Medication____________________________________________________________________

I understand that I will use this medication as directed by my physician. I will be responsible and
discreet in using this medication and should have this medication ready available.

I have been instructed how to self-administer this medication and understand the side effects of
improper use. This medication must be carried in the original labeled pharmacy container.

I will not share this medication with anyone else.

I understand that if I do not abide by these regulations, I may forfeit my right to carry and self-
administer this medication.

__________________________________________  _____________________
Student’s Signature       Date

To be completed by parent:

I give permission for my child to self-administer the medication described above. I will notify the
school nurse if this medication is no longer required or if the physician no longer directs self-
administration. The medication is to be provided by me in the original, labeled container. To my
knowledge, my child is not allergic to this medication. I hereby release Eastern Christian School
Association and its employees from any liability for injuries or other damages which may result to
the student from administration of this medication. Eastern Christian is released from any liability
should the student share this medication with another student.

__________________________________________  ________________________
Parent’s/Guardian’s Signature     Date

6/5/2014