



EASTERN CHRISTIAN SCHOOL

ASTHMA FORMS

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 to be completed and signed by the doctor. The third page is the "Self-Administration Form" 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 Preschool & Elementary School Campus is 201-445-6150; the Upper Elementary & Middle School Campus is 201-891-3663; and the High School Campus is 973-427-0900.

Thank you,

EC School Nurses



Name: _____ School: _____ DOB: ____ / ____ / ____

Severity Classification: Intermittent Mild Persistent Moderate Persistent Severe Persistent

Asthma Triggers (list): _____

Date Completed: ____ / ____ / ____ Vaccinations updated: Yes No



Green Zone: Doing Well

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

Control Medicine(s)	Medicine	How much to take	When and how often to take it	Take at
Quick Relief Medicine(s)	_____	_____	_____	<input type="checkbox"/> Home <input type="checkbox"/> School
SMART/ MART	<input type="checkbox"/> ICS/Formoterol _____ puff(s) with spacer _____ (daily max dose 12 puffs for ages 12+ yrs & 8 puffs for ages 4-11 yrs)			<input type="checkbox"/> Home <input type="checkbox"/> School
Exercise Induced	<input type="checkbox"/> Use quick-relief medicine 10 minutes before physical activity as instructed			



Yellow Zone: Caution

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

Quick-relief Medicine(s)	Medicine	How much to take	When and how often to take it
Control Medicine(s)	<input type="checkbox"/> Continue Green Zone medicines		every 20 minutes for up to 1 hour OR Nebulizer (use once)
SMART as quick reliever	<input type="checkbox"/> ICS/Formoterol _____ puff(s) with spacer _____ (daily max dose 12 puffs for ages 12+ yrs & 8 puffs for ages 4-11 yrs)		
Other	<input type="checkbox"/> _____		

You should feel better within 20–60 minutes of the quick-relief treatment. If you are getting worse THEN follow the instructions in the RED ZONE and call your doctor or 911 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 – I feel very sick

Take Quick-relief Medicine NOW!

SMART as quick reliever	Medicine	How much to take	When and how often to take it
Other	<input type="checkbox"/> _____	_____ (puffs)	_____
	<input type="checkbox"/> ICS/Formoterol _____ puff(s) with spacer _____		

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

Parent/Guardian

- I give permission for the medicines listed in the action plan to be administered in school by the nurse or designated trained staff.
- I consent to communication between the prescribing health care provider or clinic, the school nurse, the school medical advisor or school-based health clinic providers necessary for asthma management and administration of this medicine.

Name _____ Date _____ Phone (____) ____ - ____ Signature _____

Healthcare Provider

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 _____

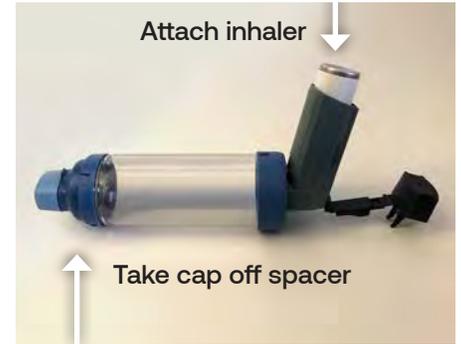
How to Use Your Inhaler and Spacer



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](https://www.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**.



EASTERN CHRISTIAN
SCHOOL

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)

Date

Physician's Signature

Phone



EASTERN CHRISTIAN
SCHOOL

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 **readily 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