

PARENT LETTER RE: SELF ADMINISTRATION OF MEDICATION FOR ASTHMA

The Sussex County Charter School for Technology Board of Trustees will permit the self-administration of an inhaler by a student for Asthma control provided that:

- The parents or legal guardian of the student provide the Superintendent and the School Nurse written authorization from the healthcare provider for self-administration of the inhaler.
- The parents or legal guardian of the student provide the School Nurse written certification from the healthcare provider that the student has a need for the use of an inhaler and has been trained in the proper method of and is competent to self-administer the inhaler.
- The parents or legal guardian of the student sign a statement acknowledging the school shall incur no liability as a result of any injury arising from the self-administration of the medication by the student and the parents or legal guardian shall indemnify and hold harmless the school, the Board of Trustees & its employees or agents from any and all claims arising out of the self-administration of the medication.
- The permission is effective for the school year in which it is granted and must be renewed for each subsequent school year.

For your convenience, a form to be completed by your healthcare provider and you is attached; should you have any question, please feel free to contact your child's School Nurse.

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ASTHMA SELF MEDICATION FORM
TO BE COMPLETED BY THE HEALTHCARE PROVIDER

STUDENT NAME: _____ **DATE OF BIRTH** _____

I am prescribing the following medication for the above named student and recommend this student be allowed to self-administer the medication for **Asthma Control**. This student would not be able to attend school if the medication is not administered during school hours. He/she is free of contagious disease and is physically fit to attend school.

Name of medication:

Diagnosis:

Dosage:

Condition under which medication is to be used:

Length of time medication is to be used:

Potential side effects:

Restrictions this medication may have on student activities:

This student has been instructed in the proper method of self-administration and in my professional opinion is competent to self-administer the above prescribed medication.

Medication may be kept in the students' possession.

Healthcare Provider's Name (print) _____

Healthcare Provider's Signature/Title _____

Telephone Number _____ **Date** _____

PAGE TWO TO BE COMPLETED BY A PARENT OR GUARDIAN

I give permission for my child to self-administer the medication for Asthma control as prescribed. I understand the **Sussex County Charter School for Technology** shall incur no liability as a result of any injury arising from the self-administration of the medication by my child and I shall indemnify and hold harmless the school, the Board and its employees or agents from any and all claims arising out of the self-administration of this prescribed medication.

It is further understood that my child will secure this medication in such a manner that it will not be available to other students. My child will report each administration of medication to the School Nurse and any side effects, letting a teacher, coach or an individual in charge know if the School Nurse is unavailable.

Parent/Guardian's Name (print)

Parent/Guardian's Signature

Cell Phone Number

Date

Work Phone Number

Superintendent's Signature

Nurse's Signature

TO BE COMPLETED BY A PARENT OR GUARDIAN

Asthma Treatment Plan – Student

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



(Please Print)

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

HEALTHY (Green Zone) IIII ➔



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
<input type="checkbox"/> Advair® HFA <input type="checkbox"/> 45, <input type="checkbox"/> 115, <input type="checkbox"/> 230	_____ 2 puffs twice a day
<input type="checkbox"/> Aerospir™	_____ <input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs twice a day
<input type="checkbox"/> Abusco® <input type="checkbox"/> 80, <input type="checkbox"/> 160	_____ <input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs twice a day
<input type="checkbox"/> Dulera® <input type="checkbox"/> 100, <input type="checkbox"/> 200	_____ 2 puffs twice a day
<input type="checkbox"/> Flovent® <input type="checkbox"/> 44, <input type="checkbox"/> 110, <input type="checkbox"/> 220	_____ 2 puffs twice a day
<input type="checkbox"/> Qvar® <input type="checkbox"/> 40, <input type="checkbox"/> 80	_____ <input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs twice a day
<input type="checkbox"/> Symbicort® <input type="checkbox"/> 80, <input type="checkbox"/> 160	_____ <input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs twice a day
<input type="checkbox"/> Advair Diskus® <input type="checkbox"/> 100, <input type="checkbox"/> 250, <input type="checkbox"/> 500	_____ 1 inhalation twice a day
<input type="checkbox"/> Asmanex® Twisthaler® <input type="checkbox"/> 110, <input type="checkbox"/> 220	_____ <input type="checkbox"/> 1, <input type="checkbox"/> 2 Inhalations <input type="checkbox"/> once or <input type="checkbox"/> twice a day
<input type="checkbox"/> Flovent® Diskus® <input type="checkbox"/> 50 <input type="checkbox"/> 100 <input type="checkbox"/> 250	_____ 1 inhalation twice a day
<input type="checkbox"/> Pulmicort Flexhaler® <input type="checkbox"/> 90, <input type="checkbox"/> 180	_____ <input type="checkbox"/> 1, <input type="checkbox"/> 2 Inhalations <input type="checkbox"/> once or <input type="checkbox"/> twice a day
<input type="checkbox"/> Pulmicort Respules® (Budesonide) <input type="checkbox"/> 0.25, <input type="checkbox"/> 0.5, <input type="checkbox"/> 1.0	_____ 1 unit nebulized <input type="checkbox"/> once or <input type="checkbox"/> twice a day
<input type="checkbox"/> Singulair® (Montelukast) <input type="checkbox"/> 4, <input type="checkbox"/> 5, <input type="checkbox"/> 10 mg	_____ 1 tablet daily
<input type="checkbox"/> Other	
<input type="checkbox"/> None	

Remember to rinse your mouth after taking inhaled medicine.

If exercise triggers your asthma, take _____ puff(s) _____ minutes before exercise.

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:
 - _____
 - _____
 - _____

CAUTION (Yellow Zone) IIII ➔



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
<input type="checkbox"/> Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	_____ 2 puffs every 4 hours as needed
<input type="checkbox"/> Xopenex®	_____ 2 puffs every 4 hours as needed
<input type="checkbox"/> Albuterol <input type="checkbox"/> 1.25, <input type="checkbox"/> 2.5 mg	_____ 1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Duoneb®	_____ 1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Xopenex® (Levalbuterol) <input type="checkbox"/> 0.31, <input type="checkbox"/> 0.63, <input type="checkbox"/> 1.25 mg	_____ 1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Combivent Respimat®	_____ 1 inhalation 4 times a day
<input type="checkbox"/> Increase the dose of, or add:	
<input type="checkbox"/> Other	

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

EMERGENCY (Red Zone) IIII ➔



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
<input type="checkbox"/> Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	_____ 4 puffs every 20 minutes
<input type="checkbox"/> Xopenex®	_____ 4 puffs every 20 minutes
<input type="checkbox"/> Albuterol <input type="checkbox"/> 1.25, <input type="checkbox"/> 2.5 mg	_____ 1 unit nebulized every 20 minutes
<input type="checkbox"/> Duoneb®	_____ 1 unit nebulized every 20 minutes
<input type="checkbox"/> Xopenex® (Levalbuterol) <input type="checkbox"/> 0.31, <input type="checkbox"/> 0.63, <input type="checkbox"/> 1.25 mg	_____ 1 unit nebulized every 20 minutes
<input type="checkbox"/> Combivent Respimat®	_____ 1 inhalation 4 times a day
<input type="checkbox"/> Other	

This asthma treatment plan is meant to assist, not replace, the clinical decision-making required to meet individual patient needs.

Obstructions: The use of this asthma treatment plan and the associated medication is intended to be used as a guide only. The use of this asthma treatment plan does not constitute a medical diagnosis or treatment. The use of this asthma treatment plan is intended to be used in accordance with the instructions of the manufacturer. The use of this asthma treatment plan is intended to be used in accordance with the instructions of the manufacturer. The use of this asthma treatment plan is intended to be used in accordance with the instructions of the manufacturer.

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 _____

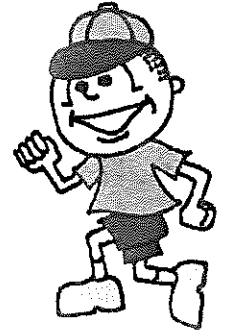
PHYSICIAN STAMP

REVISED MAY 2017

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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.

- Parents/Guardians: Before taking this form to your Health Care Provider, complete the top left section with:**
 - Child's name
 - Child's doctor's name & phone number
 - Parent/Guardian's name & phone number
 - Child's date of birth
 - An Emergency Contact person's name & phone number
- 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
- 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
- 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 _____