BAYONNE BOARD OF EDUCATION

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ASTHMA MEDICATION ADMINISTRATION

PHYSICIAN INFORMATION SHEET

POLICY ON ASTHMA MEDICATIONS

The Board of Education disclaims any and all responsibility for the diagnosis and treatment of the illness of any pupil. The Board recognizes that the attendance of a pupil may be contingent upon the timely administration of medication duly prescribed by a physician and will permit the dispensation of medication in school only when the pupil's health and continuing attendance in school so require and when the medication is administered in accordance with this policy and the following procedure.

ADMINISTRATION OF ASTHMA MEDICATION

1. If a school nurse is not present to administer the medication, the parent will be responsible for the administration of the medication.

2. Prior to the administration of a p.r.n. medication of asthma, an assessment will be performed by the school nurse.

3. If by this assessment, the nurse determines the student is too distressed to remain in school, the parent will be notified, and if necessary, emergency services contacted.

4. If the school nurse determines the student may remain in school, the medication will be administered.

5. Within one hour of administration of a p.r.n. medication, the student will again be assessed by the school nurse to determine the effectiveness of the medication. The parent will be notified if the child's condition has worsened. (see #3).

6. If sufficient relief has been obtained, the student may remain in school. The parent will be notified of the episode.

7. Under no circumstances will the medication be repeated.

8. A student will be permitted to carry an inhaler on their person and self medicate if the treating physician authorizes the student to do so.

9. If a student is too young or does not demonstrate sufficient maturity to carry the inhaler or self-medicate, it may be kept in the school health office.

BAYONNE PUBLIC SCHOOLS
BAYONNE, NEW JERSEY

SCHOOL: _____

AUTHORIZATION FOR ASTHMA MEDICATION TO BE TAKEN DURING SCHOOL HOURS

Child's Name: _____ DOB: _____ Weight: _____

Physician's Name: _____

Physician's Address: _____ Telephone No: _____

I request that my child be assisted in taking the medicine(s) described on the attached form at school by the school nurse or be permitted to self medicate as also authorized by me and my physician (see attached).

I agree to bring the medication, in its original container, properly labeled, to the school nurse. If the medication is given daily, I will bring in a weekly supply.

I further understand that in the absence of the school nurse, it is my responsibility to administer the medication.

I release and waive, and further agree to indemnify, hold harmless or reimburse the Board of Education, the individual Trustees, administrators, agents, employees and representatives Thereof from and against any claim which I, or any other parent or guardian, any sibling, the student, or any other person who may have claim to have, known or unknown, directly or indirectly, for any losses, damages, or injuries arising out of, during, or in connection with the student's self administration of his/her medication. I warrant that id this permission form is signed by one of two parents or guardians; it is with the authority of the other.

_____ _____
Parent/Guardian Signature Date

_____ _____
Home Phone Number Emergency Phone Number

Revised 1/2013

Asthma Treatment Plan – Student

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

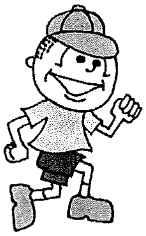
The Pediatric/Adult Asthma Coalition of New Jersey
"Your Pathway to Asthma Control"
PACNJ approved Plan available at www.pacnj.org
Sponsored by AMERICAN LUNG ASSOCIATION. IN NEW JERSEY
NJ Health New Jersey Department of Health

(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	

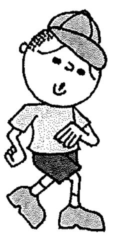
And/or Peak flow above ________

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.

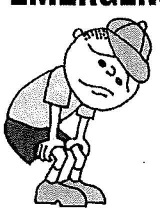
And/or Peak flow from______ to______

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

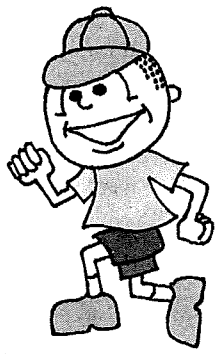
PARENT/GUARDIAN SIGNATURE____________________

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"
PACNJ approved Plan available at www.pacnj.org

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Sponsored by
AMERICAN LUNG ASSOCIATION. IN NEW JERSEY