



Dear Parent/Guardian,

Your child's health record indicates that he/she has a history of Asthma or other related respiratory concern which requires the use of an inhaler.

District Policy requires the following information:

1. Asthma Action Plan
2. Authorization to Self-Administer

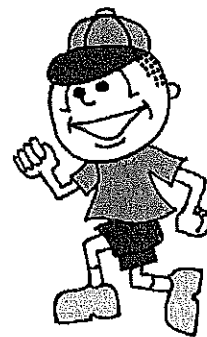
In order to participate in the school athletic program, school sponsored activities and attend field trips, the above forms must be completed and submitted to the School Nurse.

If your child no longer has Asthma, please provide a note from your child's physician stating he/she no longer has Asthma or other related respiratory concerns.

Sincerely,

Mrs. J. Ioannou, RN
Mrs. C. Quaglio, RN
School Nurses

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.

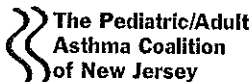
RECOMMENDATIONS ARE EFFECTIVE FOR ONE (1) SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY

- 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 _____



"Your Pathway to Asthma Control"
PACNJ approved Plan available at
www.pacnj.org

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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 5U9CE000191-5. Its content are solely the responsibility of the authors and do 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 wholly or in part by the United States Environmental Protection Agency under Agreement XA96296601-2 to the American Lung Association in New Jersey, it has not gone through the Agency's publications review process and therefore, may not necessarily reflect 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.

Sponsored by



**Morris County School of Technology Physician Certification for Self-Medication for
ASTHMA INHALER
N.J.S.A. 18A:40-12.3**

NAME OF STUDENT _____ SCHOOL _____

ACADEMY _____ GRADE _____

MEDICAL CONDITION _____

MEDICATION/DOSAGE _____

TIME TO BE ADMINISTERED _____

POSSIBLE SIDE EFFECTS _____

SCHOOL YEAR _____

I certify that the aboved name student student suffers from the above medical condition which is a potentially life-threatening illness. I have discussed the administration of this medication with the above-named student; and I certify that he/she is capable of, and has been instructed in, the proper method of self-administration of the medication in an emergency situation as directed above.

Physician's Signature

Date

Physician's STAMP

**Parent Acknowledgment and Authorization Pursuant to
N.J.S.A. 18A:40-12.3**

I hereby authorize my child to carry his/her medication during school, on field trips and during school-sponsored extracurricular activities. My child has been instructed on self-administration of the medication in potentially life threatening situations as evidenced by my submission of the above Physician Certification. I also understand that I am responsible for providing the medication and am responsible for replacing it if it has expired or been used.

By also signing the Acknowledgment, I understand that the Board of Education, its employees or agents shall incur no liability as a result of any injury arising from the self-administration or medication of the student; and I hereby indemnify and hold harmless the Board and its offices, employees and agents against any claims arising out of the self-administration of medication by the student.

This permission is effective the current school year only and will be reviewed each subsequent school year if the medication needs to be continued.

Parent or Guardian Signature

Date

I give permission for the school nurse to release my child's health concern as indicated above, to the staff at MCVTS. The school nurse may also indicated this health concern on the Genesis Program.

Parent signature

Date