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Dear Parent or Guardian:

New Jersey Law requires each Asthmatic Student in our school district to have an Individual Emergency Asthma Treatment Care Plan completed by your physician. This Treatment Plan will be utilized in the event your child has an asthma flare-up at school.

Please take this packet to your child's physician. Attached are forms regarding medication administration which are to be completed by yourself and your physician.

Dear Physician:

NJ state law states "that each student authorized to use asthma medication or a nebulizer pursuant to N.J.S.A. 18A:40-12.3, have an asthma treatment plan prepared by the student's physician, which shall identify at a minimum, asthma triggers and an individualized healthcare plan, pursuant to N.J.A.C. 6A:16-2.1(a), for meeting the medical needs of the student while attending school or a school-sponsored event."

Your patient has been identified to be in need of an Individual Asthma Emergency Treatment Plan. In an effort to simplify the paperwork, I have developed an Asthma Treatment Plan for your review. This is an emergency care plan that will be utilized in the event your patient has an asthma flare-up while at school.

If you are interested in using this plan, please complete the appropriate sections and return the form. If this plan is not acceptable, please submit an alternate plan which contains information regarding known asthmatic triggers, current medication and emergency treatment instructions.

In addition, there are two additional forms regarding medication administration that need to be completed and returned to the school nurse:

1. *SCHOOL NURSE AUTHORIZATION FOR ADMINISTRATION PRESCRIPTION MEDICATION*. This form provides permission for the school nurse to administer Asthma related medication to your patient. One form per medication. **This should be completed for all students.**

2. *STUDENT AUTHORIZATION FOR SELF ADMINISTRATION OF DAILY AND AS NEEDED ASTHMA PRESCRIPTION MEDICATION*. This form allows your patient to carry and administer his/her own asthma medication. One form per medication. **Please complete only if appropriate for your patient.**

If you have any questions, please contact me at my office.

Sincerely,

Ronald M Frank, MD FAAFP
School Medical Inspector

V2011

Individual Asthma Emergency Treatment Plan

Student's Name: _____
Student's DOB: _____

Grade: _____
Date: _____

Physician's Name: _____
Physician's Telephone Number: _____

Known Triggers:

<input type="checkbox"/> Carpets/stuffed animals	<input type="checkbox"/> Pests (rodents/cockroaches)
<input type="checkbox"/> Chalk dust	<input type="checkbox"/> Pets / animal dander
<input type="checkbox"/> Cigarette smoke	<input type="checkbox"/> Plants/grass/trees/pollen/flowers
<input type="checkbox"/> Colds/URI's	<input type="checkbox"/> Strong odors/perfumes, ect
<input type="checkbox"/> Dust/Dust mites/	<input type="checkbox"/> Sudden temperature changes
<input type="checkbox"/> Exercise	<input type="checkbox"/> Wood Smoke
<input type="checkbox"/> Mold	<input type="checkbox"/> Foods: _____
<input type="checkbox"/> Ozone Alert days	<input type="checkbox"/> Other: _____

Current Asthma and Allergic Rhinitis Medications :(meds/ dosages/frequency)

Treatment instructions:

1. In the event of an asthma flare-up , the student will report to the school nurse for assessment. If the child has previously been designated to self-administer a rescue MDI, they will be allowed to utilize their MDI until medically evaluated by the school nurse. A Parent/Guardian will be contacted.
2. The School Nurse will assess the student and if the student requires treatment for Asthma, **administer Albuterol 0.083% 2.5mg in 3ml unit dose Nebulizer Solution every 15min as needed for up to 3 doses.** The student's disposition (i.e. whether he/she can remain at school or be sent for medical evaluation) will be dependent on this initial treatment outcome.
3. If after 3 nebulizer treatments the student is still symptomatic you may continue to administer **Albuterol 0.083% 2.5mg in 3ml unit dose Nebulizer Solution every 15min** while waiting for transportation to their primary physician or ER depending on the severity of symptoms.
4. If the student (who remained at school after the first course of treatment) develops a flare-up of symptoms later that day, treatment protocol will be re-instituted; the student will not be allowed to remain in school and must be referred to their primary physician or ER depending on the severity of symptoms.
5. If respiratory distress is part of an anaphylactic reaction, administer Epinephrine and Diphenhydramine as per the school's standing orders or individual student orders if available. Call EMS ASAP.

Signature of Physician: _____ Date: _____
Physician Stamp:

**SCHOOL NURSE AUTHORIZATION FOR ADMINISTRATION OF
PRESCRIPTION MEDICATION**

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

The following section is to be completed by the PARENT/GUARDIAN:

Student's Name

Grade

I request that my child be assisted in taking the medication described below at school by the School Nurse or other individuals authorized to administer medication to students in school pursuant to N.J.A.C.:6A:16-2.3. I understand the ultimate responsibility for administration of the medication is mine, and I am fully aware that the duties of the school nurse and others may require their presence at another location at the time that the medication is needed. 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 administration or lack of administration 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 administration or lack of administration of this medication.

Parent/Guardian Signature

Telephone

Date

The following section is to be completed by the Medical Provider:

Name of medication: _____

Dosage: _____ Route: _____ Frequency: _____

If this is a daily administered medication, when should it be given? _____

If medicine is to be given "PRN", describe indications: _____

How soon can the "PRN" medicine be repeated? _____

List significant side effects: _____

Any restrictions or limitations: _____

****PLEASE CHECK THE APPROPRIATE OPTION WHEN A PARENT IS UNABLE TO ATTEND A CLASS TRIP**

_____ The prescribed dose can be withheld on the day of the class trip.

_____ The time to be given can be adjusted with the parent/guardian.

_____ This medication must be given to the child at the scheduled time.

Physician's Name

Address

Telephone no.

Physician's Signature

Date

This form must be individually completed for **all prescribed medications**.

Medications are to be brought to school by the parent in the **original container**, labeled appropriately by the pharmacy.

All medications **will be kept** in a locked storage area.

It **may not** be possible to administer daily medication on half session days, early dismissal days or delayed opening days at the prescribed time. Parent/guardian will be notified if the medication could not be given to the student.

