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FAMILY MEDICINE

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April 25, 2011

Dear Parent or Guardian:

New Jersey Law requires each Asthmatic Student in our school district to have an Individual Asthma Treatment Care Plan completed by your medical provider. This Treatment Plan will be utilized in the event your child has an asthmatic attack at school.

Please take this packet to your physician for their review and completion. In addition, there are two 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 pursuant to N.J.S.A. 18A:40-12.3, or a nebulizer, 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 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 asthmatic attack 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 forms regarding medication administration.

The first form: *SCHOOL NURSE AUTHORIZATION FOR IN-SCHOOL ADMINISTRATION OF DAILY AND AS NEEDED ASTHMA PRESCRIPTION MEDICATION* provides permission for the school nurse to administer Asthma related medication to your patient. This should be completed for all students.

The second form *STUDENT AUTHORIZATION FOR IN-SCHOOL SELF ADMINISTRATION OF DAILY AND AS NEEDED ASTHMA PRESCRIPTION MEDICATION* allows your patient to carry and administer his/her own asthma 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

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Individual Asthma Treatment Plan

Student's Name: _____ Grade: _____
Student's DOB: _____ Date: _____

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

Known Triggers:

___Carpets/stuffed animals
___Chalk dust
___Cigarette smoke
___Colds/URI's
___Dust/Dust mites/
___Exercise
___Mold
___Ozone Alert days
___Pests (rodents/cockroaches)
___Pets / animal dander
___Plants/grass/trees/pollen/flowers
___Strong odors/perfumes, ect
___Sudden temperature changes
___Wood Smoke
___Foods:_____
___Other:_____

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

_____

_____

_____

Treatment instructions:

1. In the event of an acute asthmatic attack, 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. 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. 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 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:_____

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SCHOOL NURSE AUTHORIZATION FOR IN-SCHOOL ADMINISTRATION OF DAILY AND AS NEEDED ASTHMA PRESCRIPTION MEDICATION

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

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

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 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 daily medication could not be given to the student.

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STUDENT AUTHORIZATION FOR IN-SCHOOL SELF ADMINISTRATION OF DAILY AND AS NEEDED ASTHMA PRESCRIPTION MEDICATION

N.J.S.A. Title 18A:40-12.3 directs that students may be permitted to self administer medications for asthma or other potentially life-threatening illnesses provided proper procedures are followed. This form must be individually completed for **all prescribed medications**.

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

_____ _____
Student's Name **Grade**

I 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 on this form for the current school year as I consider him/her to be responsible and capable of transporting, storing and self-administration of the medication. 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.

_____ _____ _____
Parent/Guardian Signature Telephone Date

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

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 be given "PRN", describe indications: _____

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

List significant side effects: _____

Any restrictions or limitations: _____

I verify that the child above requires this medication and
a. This student has been instructed in and is capable of proper method of self-administration of the medication prescribed above.
b. This student understands the purpose, appropriate method and frequency of use of the medication prescribed above.
c. The student's medication, if ingested by someone other than the student will not cause severe illness or death.

_____
Physician's Name Address Telephone

_____ _____
Physician's Signature Date

Approved By School Nurse: _____ _____
Signature Date

Approved By School MD: _____ _____
Signature Date

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