

500 Tenafly Road, Tenafly, NJ 07670

Dear Parent/Guardian:

Our medication policy encourages parents to administer all medications at home; however, it is recognized that children with special needs, chronic illnesses or medical conditions and specific disabilities may require medication during the school day.

In accordance with the Board of Education POLICY AND REGULATION ON THE ADMINISTRATION OF MEDICATION, a physician's prescription and written parental consent must accompany ALL medication, both PRESCRIPTION AND NONPRESCRIPTION (over the counter).

PRESCRIPTION AND NON-PRESCRIPTION medications must be brought to school in the original container with the original label. It will be kept locked in the health office. Under no circumstances are students permitted to keep medication with them while in school.

A written statement from the physician must be brought to school at the start of each school year for those students who are on continuous daily medication or who require "as needed" medication for allergies, allergic reactions, chronic headaches, etc.

NO MEDICATION WILL BE ADMINISTERED WITHOUT THE WRITTEN PERMISSION OF THE PARENT AND PHYSICAN.

Sincerely,

Dr. Rehan Shamim School Physician

/ss

Medication Policy

I. DOCTOR'S REQUEST/INSTRUCTIONS FOR MEDICINE TO BE GIVEN BY SCHOOL NURSE. TO BE FILLED OUT BY PHYSICIAN

The following medication is to be administere	ed to my patient				
MEDICATION	DOSE AND ROUTE				
TIME GIVEN	DIAGNOSIS				
SIGNIFICANT SIDE EFFECTS					
LENGTH OF TREATMENT					
	M.D. Signature				
	Print M.D. Name				
II. DOCTOR'S REQUEST / INSTRUCTION MEDICATION FOR A POTENTL	ONS FOR STUDENT SELF-ADMINISTRATION OF ALLY LIFE THREATENING ILLNESS. TO BE FILLED OUT BY PHYSICIAN				
The following medication is to be self-administration of the restricted in the proper administration of the proper ad	atening illness and that my patient is capable of and has been				
MEDICATION	DOSE AND ROUTE				
TIME GIVEN	DIAGNOSIS				
LENGTH OF TREATMENT					
SIGNIFICANT SIDE EFFECTS					
Date	M.D. Signature				
	Print M.D. Name				
	TO BE COMPLETED BY PARENT/GUARDIAN				
have been informed by the school district that liability whatsoever as a result of any untowar hereby indemnify and hold harmless the TEN	to (receive) (self-administer) the medication designated above. I the school district, its agents, servants, and employees shall incur no rd reaction arising from the administration of medicine by my child. I AFLY BOARD OF EDUCATION, its agents, servants, and employees lawsuit that may arise out of or in connection with the administration of				
Date	Signature of Parent/Guardian				

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.

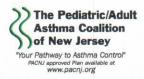
- 1. Parents/Guardians: Before taking this form to your Health Care Provider, complete the top left section with:
 - Child's name
- · Child's doctor's name & phone number

· Parent/Guardian's name

- Child's date of birth
- An Emergency Contact person's name & phone number
- & 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
 - <u>Permission to Self-administer Medication</u> 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

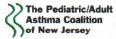
PARENT AUTHORIZATION I hereby give permission for my child to receive medication at school a in its original prescription container properly labeled by a pharmac information between the school nurse and my child's health care understand that this information will be shared with school staff on a	ist or physician. I also g provider concerning my	ive permission for the release and exchange of							
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 me in school pursuant to N.J.A.C.:.6A:16-2.3. I give permission for my of Plan for the current school year as I consider him/her to be responsed medication. Medication must be kept in its original prescription of shall incur no liability as a result of any condition or injury arising on this form. I indemnify and hold harmless the School District, its or lack of administration of this medication by the student.	child to self-administer mansible and capable of tra container. I understand the from the self-administra	nsporting, storing and self-administration of the nat the school district, agents and its employees tion by the student of the medication prescribed							
☐ I DO NOT request that my child self-administer his/her asthma r	nedication.								
Parent/Guardian Signature	Phone	Date							



Disclaimers: The use of this Website PACNJ Adhms Treatment Plan and its content is at your own risk. The content is growind on an "as is" basis. The American Lung Association of the Mid-Allantic (ALAM-A), the Pediatric/Adult Ashms Coalison of New Jessey and all affiliates disclaims all warranties, express or implied, statutory or otherwise, including but not limited to the implied warranties or mechanisation; non-interpreted or that grades grades and times so to particular justices. A JAM-A makes no metabolity, non-interpreted or expression in interpreted or particular justices. A JAM-A makes no warranty, representation or quarranty that the information will be uninterpreted or error from the or that any defines counted, and on a consequent or particular particular in order to a manages. Personal injury shorogly death, lest profits, or damages resulting from data or business interruption) resulting from the use or reachility to use the content of this Ashma Teamment Plan whether based or warranty. Contract, for or any other legal theory, and whether or not ALAM-A is advised of the possibility of such damages. ALAM-A and is affiliates are not liable for any dams.



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





Sponsored by





(Please Pri	nt)					www.pa	cnj.org		
Name					Date of Birth			Effective Date	
Doctor			Parent/Guardian (if applicable)				Emerg	gency Contact	
Phone			Phone				Phone		
	Green Zone)	n	ake daily nore effec	control mo	edicine(s). a "spacer"	Some - use	inhal if dire	ers may be cted.	Triggers Check all items
You have <u>all</u> of these: Breathing is good No cough or wheeze Sleep through the night Can work, exercise, and play			MEDICINE HOW MUCH □ Advair® HFA □ 45, □ 115, □ 230 □ □ Alvesco® □ 80, □ 160 □ □ Dulera® □ 100, □ 200 □ □ Flovent® □ 44, □ 110, □ 220 □ □ Qvar® □ 40, □ 80 □ □ Symbicort® □ 80, □ 160 □ □ Advair Diskus® □ 100, □ 250, □ 500 □ □ Asmanex® Twisthaler® □ 110, □ 220 □ □ Flovent® Diskus® □ 50 □ 100 □ 250 □ □ Pulmicort Flexhaler® □ 90, □ 180 □ □ Pulmicort Respules® (Budesonide) □ 0.25, □ 0.5, □ 1.0 □ □ Singulair® (Montelukast) □ 4, □ 5, □ 10 mg						Pests - rodents
And/or Peak fl	ow above		ther					ing inhaled medicine	cockroaches Cockroaches Cockroaches Cockroaches Cigarette smok Second hand
If	exercise triggers yo	ur asthn	na, take this n		to mise your	moutii a		utes before exercise	• Perfumes,
	Yellow Zone) You have <u>any</u> of the	*	ontinue dai	ly control mo	edicine(s) an	d ADD q	juick-re	elief medicine(s).	cleaning products, scented products
f quick-relief med 15-20 minutes or 2 times and symp doctor or go to the	Cough Mild wheeze Tight chest Coughing at night Other: licine does not help within has been used more than toms persist, call your e emergency room.	ME	MEDICINE Combivent® Maxair® Xopenex® Ventolin® Pro-Air® Proventil® Albuterol 1.25, 2.5 mg Duoneb® Xopenex® (Levalbuterol) 0.31, 0.63, 1.25 m Increase the dose of, or add: Other • If quick-relief medicine is need week, except before exercise,				to take and HOW OFTEN to take it 2 puffs every 4 hours as needed2 puffs every 4 hours as needed1 unit nebulized every 4 hours as needed1 unit nebulized every 4 hours as needed g1 unit nebulized every 4 hours as needed g1 unit nebulized every 4 hours as needed ed more than 2 times a		
And/or	Your asthma is getting worse fast: • Quick-relief medicine d not help within 15-20 m • Breathing is hard or fas ended to the end of	id innutes st show lking blue	Asthma ca MEDICINE Combivent® Ventolin® Albuterol Duoneb®	An be a life Maxair® No N	e-threaten HOW I penex® _ entil® _	MUCH to t	take and 2 puffs e 2 puffs e 1 unit net 1 un	CALL 911. Do not wait! HOW OFTEN to take it very 20 minutes very 20 minutes oulized every 20 minutes oulized every 20 minutes oulized every 20 minutes oulized every 20 minutes	This asthma treatmen plan is meant to assis not replace, the clinica decision-making required to meet individual patient need
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REVISED AUGUST 2013

☐ This student is <u>not</u> approved to self-medicate.

PHYSICIAN STAMP