Morris County
Vocational School District

Dear Parent/Guardian,

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

In order to participate in the athletic program, school-sponsored activities and field trips, the following must be completed and submitted to the School Nurse at the start of EACH school year:

District Policy requires the following information:

1. **All enclosed paperwork** in this packet must be completed by physician and parent/guardian.
2. **An inhaler** - to be kept on your child at all times (with an approval to self administer form filled out by the physician and parent/guardian if applicable).

***All forms must be dated *after July 1st* for the applicable school year.**

No longer has asthma: Provide a note from your student's physician stating he/she no longer has life-threatening allergies that require an inhaler.

12th grade students attending CCM/other colleges: These forms are required to be completed and submitted to the health office if your child plans to participate in MCST clubs, athletic teams and school sponsored events and trips

We welcome the opportunity to meet with you and your child to discuss any concerns you may have.

Sincerely,

Ms. Carol Maffei, RN

Ms. Rebecca Reinfeld, RN

School Nurses

Asthma Action Plan: English

American Academy of Allergy Asthma & Immunology

Asthma Action Plan for Home & School

Name: Birthdate:

Asthma Severity: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent
☐ He/she has had many or severe asthma attacks/exacerbations

☺ Green Zone Have the child take these medicines every day, even when the child feels well.

Always use a spacer with inhalers as directed.

Controller Medicine(s): _____

_____

Controller Medicine(s) Given in School: _____

Rescue Medicine: Albuterol/Levalbuterol _____ puffs every four hours as needed

Exercise Medicine: Albuterol/Levalbuterol _____ puffs 15 minutes before activity as needed

😐 Yellow Zone Begin the sick treatment plan if the child has a cough, wheeze, shortness of breath, or tight chest. Have the child take all of these medicines when sick.

Rescue Medicine: Albuterol/Levalbuterol _____ puffs every 4 hours as needed

Controller Medicine(s):

☐ Continue Green Zone medicines: _____

☐ Add: _____

_____

☐ Change: _____

If the child is in the **yellow** zone more than **24** hours or is getting worse, follow **red** zone and call the doctor right away!

☹ Red Zone If breathing is hard and fast, ribs sticking out, trouble walking, talking, or sleeping.
Get Help Now

Take rescue medicine(s) now

Rescue Medicine: Albuterol/Levalbuterol _____ puffs every _____

Take: _____

_____

If the child is not better right away, call 911
Please call the doctor any time the child is in the red zone.

Asthma Triggers: (List)

School Staff: Follow the Yellow and Red Zone plans for rescue medicines according to asthma symptoms.
Unless otherwise noted, the only controllers to be administered in school are those listed as "given in school" in the green zone.

☐ Both the asthma provider and the parent feel that the child may carry and self-administer their inhalers
☐ School nurse agrees with student self-administering the inhalers

Asthma Provider Printed Name and Contact Information:	Asthma Provider Signature: Date:

Parent/Guardian: I give written authorization for the medications listed in the action plan to be administered in school by the nurse or other school members as appropriate. I consent to communication between the prescribing health care provider/clinic, the school nurse, the school medical advisor and school-based health clinic providers necessary for asthma management and administration of this medication.

Parent/guardian signature: Date:	School Nurse Reviewed: Date:

Please send a signed copy back to the provider listed above.

American Academy of Allergy Asthma & Immunology

Supplementary School Treatment Form

American Academy of Allergy Asthma & Immunology
www.aaaai.org

School Supplementary Treatment Orders

(To be Sent with the Asthma Action Plan)

Student Name: Birthdate:

Asthma Rescue Medications:

See attached **Asthma Action Plan**:

Please follow the treatment plan detailed in the Green zone for activity/exercise treatment and rescue medication plan for Green, Yellow & Red zones, according to asthma symptoms.

Common side effects of albuterol/levalbuterol include increased heart and respiratory rate and jitteriness.

☐ The student may carry and self-administer their inhalers

Pre-activity treatment, including before physical education/recess, should be given:

☐ With all activity ☐ Only when the child or school staff feels he/she needs it

If a Student is in the Red Zone, immediately give their rescue treatment and call 911.
Please follow school emergency plans, according to school/school system policy.

Controller Medications:

Only the following controller or steroid medications should be administered in school:

	AM Dose	PM Dose

If not listed on the Asthma Action Plan:

Triggers:

School specific triggers include: _____

Asthma Severity: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

☐ He/she has had many or severe asthma attacks/exacerbations

Please Contact the Asthma Provider listed here with any questions or concerns regarding these orders, or if the student does not have adequate/correct medications in the school.

Asthma Provider Printed Name & Contact Information:

Asthma Provider Signature: Date:

Parent/Guardian Permission: I give permission for the medications listed in the Asthma Action Plan to be administered in the school by the nurse or other school members in accordance with school policy. I consent to sharing health information between the prescribing health care provider/clinic, the school nurse, and the school medical advisor necessary for asthma management and administration of this medication.

Parent/guardian signature: Date:

For School Use: ☐ School nurse agrees with student self-administering the inhalers

School nurse received/Signature: Date:

Please send a signed copy back to the provider at the contact listed above.

Morris County
Vocational School District

Name of Student: Grade: Diagnosis: Medication:

Section 1: To Be Completed by the Physician: Morris County School of Technology Physician Certification for Self Medication N.J.S.A 18A:40-12.3

I certify that the above name student has the above medical condition which is a potentially life threatening illness. I have discussed the administration of this medication with the above student, and certified 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

Section 2: To be Completed by the Parent/Guardian: Parent Acknowledgement and Authorization Pursuant to N.J. S.A 18A:40-12.3.

A. I give permission for the school nurse to release my child's health concerns as indicated above, to the staff at MCVTS. The school nurse may have indicated this health concern in the genesis program.

Parent/ Guardian Signature Date

B. Permission to self-carry and self- administer their prescribed medication during school hours and during athletic or school sponsored events. I acknowledge that the district shall incur no liability as a result of any injury arising from the self-administration of medication by my child and that I shall indemnify and hold harmless the district and its employees or agents against any claims arising out of the self-administration of medication by the pupil.

Parent/ Guardian Signature Date

Section 3: To be Completed by the MCST Student: Student Acknowledgement Pursuant to N.J. S.A 18A:40-12.3.

- I understand and I will use this medication as directed by my physician.
- I will be responsible for carrying and using this medication as described while in school, on field trips, athletic events and at any other school sponsored event.
- I understand to keep the supplies for self-management with me at all times and that all medication mentioned in the prescribed self-management plan must be in its original labeled container, at all times.
- I am aware that I must report to the school nurse or delegate if there are any deviations from the parameters set in the self-management plan.

Student Name Date

Morris County
Vocational School District

Name of Student: Grade:

Section 3: To be Completed by the MCST Student: Acknowledge of Medication Self Administration Policies (*if applicable*).

- I understand and I will use this medication as directed by my physician.
- I will be responsible for carrying and using this medication as described while in school, on field trips, athletic events and at any other school sponsored event.
- I understand that my self-management supplies must be kept and used in an appropriate manner within the school setting, using universal precautions.
- I understand to keep the supplies for self-management with me at all times and that all medication mentioned in the prescribed self-management plan must be in its original labeled container, at all times.
- I am aware that I must report to the school nurse or delegate if there are any deviations from the parameters set in the self-management plan.

Student Name Date