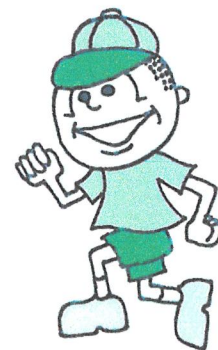


Asthma Treatment Plan – Student

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 & phone number
- Child's date of birth
- An Emergency Contact person'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

Disclaimers: The use of this Website/PACNJ Asthma Treatment Plan and its contents is at your own risk. The content is provided on an "as is" basis. The American Lung Association or the Mid-Atlantic (ALAM-A), the Pediatric/Adult Asthma Coalition of New Jersey and all affiliates disclaim all warranties, express or implied, statutory or otherwise, including but not limited to the implied warranties of merchantability, non-infringement of third parties' rights, and fitness for a particular purpose. ALAM-A makes no representations or warranties about the accuracy, reliability, completeness, currency, or timeliness of the content. ALAM-A makes no warranty, representation or guaranty that the information will be uninterrupted or error free or that any defects can be corrected. In no event shall ALAM-A be liable for any damages (including, without limitation, incidental and consequential damages, personal injury, wrongful death, lost profits, or damages resulting from data or business interruption) resulting from the use or inability to use the content of this Asthma Treatment Plan whether based on warranty, contract, tort or any other legal theory, and whether or not ALAM-A is advised of the possibility of such damages. ALAM-A and its affiliates are not liable for any claim, whatsoever, caused by your use or misuse of the Asthma Treatment Plan, nor of this website.

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Sponsored by

PARENT/GUARDIAN PERMISSION FOR MINOR STUDENT TO SELF-ADMINISTER MEDICATION

I, the parent/guardian of _____ authorize my child, a pupil at The Wardlaw+Hartridge School to self-administer medication prescribed by our physician as described below for a life-threatening condition. Such Medication is generally limited to Asthma Inhaler, pre-filled Epinephrine auto-injector with or without a unit dose of Benadryl, and Diabetic Care/Medications. I understand that this permission is valid only for this school year and must be renewed for each school year, should my child's condition require it. I further understand that neither The Wardlaw+Hartridge School employee/nurse, and/or MOESC nurse/third party hired school nurse/ or dually employed nurse, shall be responsible for any liability as a result of any injury arising from the self-administration of this medication by my child, or misuse of the medication. I agree that this information will be shared on a need to know basis with school personnel. All medications must be non-expired and be brought to school in an original, unopened labeled pharmacy container, including for over-the-counter medications.

Parent/Guardian Signature _____ print name _____ Date _____
(***See other side****) 2-sided document 18 and over must sign this form

PHYSICIAN'S AUTHORIZATION/ASSURANCE STATEMENT FOR STUDENT'S

SELF-ADMINISTRATION OF MEDICATION I certify that _____ is under my care for a life-threatening condition. I am recommending that the above-named student be permitted to self-administer medication. He/She is capable of, and has been instructed by me in the proper method of self-administration of the following medications: (Such medication is generally limited to Asthma Inhaler, pre-filled Epinephrine auto-injector with or without a unit dose of Benadryl, and IDDM meds)

Name and Purpose of Medication: _____

Identification of life-threatening medical problems: _____

Prescribed dosage/route/schedule: _____

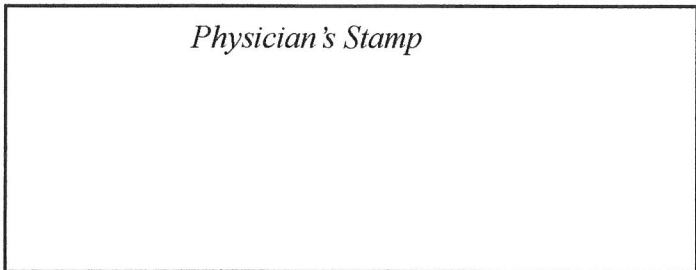
Length of time medication to be taken: _____

Possible side effects and/or special precautions: _____

Prescribing Physician's Signature

Please print name and address of Prescribing Physician

Telephone # _____ date _____



Neither the W+HS, nor any employee/nurse(s), nurse's agents/nurse-employers/MOESC/third party hired nurse/dually employed nurse, shall be responsible for any liability as a result of injury to the above-named student, arising from the self-administration of medication or any misuse of the medication

Parent Form (see other side; 2-sided document**)**

Self-Administration Policy & Release

Students who self-administer must be authorized to do so **in writing** by their doctor and parent, and as approved by the school nurse. See school nurse for forms. “Self-Administrators” are responsible to carry and self-administer their approved medications **with them at all times**. This includes before, during, and after school, as well as **any and all** school functions, performances, trips, clubs, activities, or sports events. The medication(s) the student’s doctor orders must be sent with the student daily **from home**. As a parent, you agree to oversee that your student has the **appropriate, un-expired, properly pharmacy labeled** medications with them daily. Parent agrees to share this policy, and review this policy with your child. Student and parent agree not to share his/her medications with anyone. Furthermore, all agree the student will tell the person in charge of the school event they have taken medication. The school nurse should also be informed when available. Students must seek adult help immediately at any time he/she needs to, or if there is a problem or concern, as well as seek out school nurse/s with questions.

We agree to indemnify and hold harmless the Wardlaw+Hartridge School, its employees/agents/nurse/s, nurse’s employer(s) agents, MOESC/third-party hired nurse/dually employed nurse from any claims arising from failure of parent or student to follow this policy/procedure.

I understand and have instructed my child, along with his or her doctor’s guidance, in proper use, storage, and administration of the prescribed medication(s). I will only send in the prescribed amount needed.

Self-administrators are also required to keep a “back-up” set of medications in the nurse’s office for emergency use (while still carrying a set of their “own” medications with them daily).

Student Name _____

Parent/Guardian print name _____

Parent/Guardian signature _____

THE WARDLAW+HARTRIDGE SCHOOL AUTHORIZATION FOR MEDICATION IN SCHOOL

The following section is to be completed by the **PARENT**:

School Year: 20__ - 20__

Child's Name: _____ Date of birth: _____ grade: _____

I request that my child be assisted in taking the medicine described below at school by authorized persons. The medication prescribed below is needed during school hours for my child to properly function and cannot be given at home. Herbal and dietary supplements are not considered medications and cannot be given in school. All medication must be **brought to school by a parent/guardian, in an original unopened labeled pharmacy container**, including for over-the-counter medications also. Please check and note the expiration date. At the conclusion of treatment/school year (whichever is first) parent/guardian **must pick up** medication or it will be **discarded** on the last day of school. Changes to regime must be put in writing by prescribing physicians. I agree that information may be shared with appropriate school personnel on a need to know basis. Neither the Wardlaw+Hartridge School/ employees or school nurse/s, nurse's agent/nurse-employers/MOESC/third party hired nurse/dually employed nurse, shall be responsible for any liability as a result of any injury arising from the authorized administration of medication.

Date PRINT NAME parent/guardian

Parent/Guardian Signature

Students 18 and over must sign form themselves

The following section is to be completed by the **PHYSICIAN**:

Child's name: _____ DOB: _____ Diagnosis: _____

Medication: _____ Dosage: _____ Route: _____

If medicine is to be given daily, at what time? _____

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

How soon can it be repeated? _____

Length of time this treatment is recommended: _____

Print Physician's Name: _____

Signature of physician: _____

Address/telephone number _____

Date: _____

