



500 Tenafly Road, Tenafly, NJ 07670

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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 PHYSICIAN.

Sincerely,

A handwritten signature in black ink, appearing to read 'R. Shamim', written in a cursive style.

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 administered 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 / INSTRUCTIONS FOR STUDENT SELF-ADMINISTRATION OF  
MEDICATION FOR A POTENTIALLY LIFE THREATENING ILLNESS.**

**TO BE FILLED OUT BY PHYSICIAN**

The following medication is to be self-administered by my patient, \_\_\_\_\_.

I hereby certify that my patient has a life threatening illness and that my patient is capable of and has been instructed in the proper administration of the required medication.

MEDICATION \_\_\_\_\_ DOSE AND ROUTE \_\_\_\_\_

TIME GIVEN \_\_\_\_\_ DIAGNOSIS \_\_\_\_\_

LENGTH OF TREATMENT \_\_\_\_\_

SIGNIFICANT SIDE EFFECTS \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
M.D. Signature

\_\_\_\_\_  
Print M.D. Name

**III. PARENT REQUEST AND RELEASE**

**TO BE COMPLETED BY PARENT/GUARDIAN**

I request my child, \_\_\_\_\_ to (receive) (self-administer) the medication designated above. I have been informed by the school district that the school district, its agents, servants, and employees shall incur no liability whatsoever as a result of any untoward reaction arising from the administration of medicine by my child. I hereby indemnify and hold harmless the **TENAFLY BOARD OF EDUCATION**, its agents, servants, and employees from any and all claims and shall defend any lawsuit that may arise out of or in connection with the administration of medicine by my child.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian

# SCHOOL OR CHILD CARE ASTHMA/ALLERGY ACTION PLAN



Asthma and Allergy  
Foundation of America  
aafa.org

Attach or insert  
ID photo

Name:	
DOB:	
Parent/Guardian #1 Name:	
Address:	
Phone (home):	Phone (work):
Parent/Guardian #2 Name:	
Address:	
Phone (home):	Phone (work):
Emergency Contact #1 Name:	
Relationship:	Phone:
Emergency Contact #2 Name:	
Relationship:	Phone:
Physician Child Sees for Asthma/Allergies:	
Phone:	
Other Physician:	
Phone:	

## Daily Asthma Management Plan

### Identify the Things That Start an Asthma/Allergy Episode

(Check each that applies to the child)

- |              |                  |       |                        |
|--------------|------------------|-------|------------------------|
| Animals      | Bee/insect sting | Latex | Respiratory infections |
| Dust mites   | Exercise         | Smoke | Change in temperature  |
| Pollens      | Chalk dust/dust  | Molds | Strong odors           |
| Food: _____  |                  |       |                        |
| Other: _____ |                  |       |                        |

### Control of Child Care Environment

(List any environmental control measures, pre-medications, and/or dietary restrictions that the child needs to prevent an asthma/allergy episode.)

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## Daily Medication Plan for Asthma/Allergy (Emergency medicines listed on next page)

MEDICINE	HOW MUCH	HOW OFTEN/WHEN TO USE

## Outside Activity and Field Trips (List medications that must accompany the child when participating in outside activities and/or field trips)

MEDICINE	HOW MUCH	HOW OFTEN/WHEN TO USE

# Asthma Emergency Plan

Emergency action is necessary when the child has symptoms such as:

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## Steps to Take During an Asthma Episode:

1. Assess symptoms.
2. Give emergency asthma medications as listed below.

MEDICINE	HOW MUCH	HOW OFTEN/WHEN TO USE

3. Check symptoms after \_\_\_\_ minutes. Give medicine again if symptoms have not improved.
4. Allow child to stay in school or at child care setting if:

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5. Contact parent/guardian.
6. **Seek emergency medical care if the child has any of the following:**

**Signs and symptoms of severe asthma episode**

- No improvement after treatment
- Hard time breathing with:
  - Chest and neck pulled in with breathing
  - Child hunched over
  - Nose opens wide
  - Trouble walking or talking
- Stops playing and cannot start activity again
- Lips, gums, or fingernails turn gray or white on darker skin or blue on lighter skin

  
**Severe symptoms  
need immediate  
treatment and  
medical help**

# Allergy Emergency Plan

Child is allergic to:

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## Steps to Take During an Allergy Episode:

1. Assess symptoms.
2. Give medicine as listed below.

MEDICINE	HOW MUCH	HOW OFTEN/WHEN TO USE

3. Check symptoms after \_\_\_\_ minutes.
4. Allow child to stay in school or at child care setting if:

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5. Contact parent/guardian.
6. **Seek emergency medical care if the child has any of the following:**

**Symptoms of severe allergic reaction**

- Mouth/Throat: itching and swelling of lips, tongue, mouth, throat; throat tightness; hoarseness; cough
- Skin: hives; itchy rash; swelling
- Gut: nausea; abdominal cramps; vomiting; diarrhea
- Lung\*: shortness of breath; coughing; wheezing
- Heart: pulse is hard to detect; "passing out"

\*If child has asthma, asthma symptoms may also need to be treated.

## Special Instructions

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I have instructed \_\_\_\_\_ in the proper way to use their medications. It is my professional opinion that they should carry their asthma/allergy medicines by themselves.

It is my professional opinion that \_\_\_\_\_ should not carry their asthma/allergy medicines by themselves.

Physician Signature

Date

Parent/Guardian Signature

Date

Child Care Provider's Signature

Date