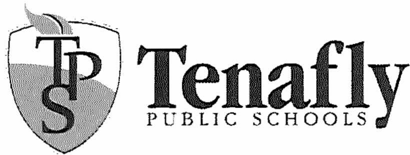

500 Tenafly Road, Tenafly, NJ 07670

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

Office of the Nurse

TENAFLY HIGH SCHOOL
19 Columbus Drive
Tenafly, NJ 07670-1698
Tel: 201-816-6670
Fax: 201-837-1035

PARENT PERMISSION FORM FOR STAFF TO ADMINISTER EPINEPHRINE OR INHALER IN THE ABSENCE OF THE SCHOOL NURSE

I give my permission to have a teacher or other staff member of the Tenafly School District administer Epinephrine or inhaler to my child in the event of any emergency in which a school nurse is not available. You may release any appropriate information to staff involved with my child.

STUDENT NAME ____

____
PARENT/GUARDIAN SIGNATURE

____
DATE

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.)

____

____

____

____

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:

____

____

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:

____

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

Allergy Emergency Plan

Child is allergic to:

____

____

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:

____

____

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 ________________________________

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

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This action plan was developed in collaboration with the National Asthma Education and Prevention Program (NAEPP) and the EPA.

BY-NC-ND

DOCUMENTATION OF AN ANAPHYLACTIC INCIDENT

The new law (NJSA 18A: 40-12.5) mandates that the use of an Epi Pen as a first treatment must be based on previously documented anaphylactic incident.

Student's Name ______________________ **DOB** ____________ **Grade** ________

Reviewed By ______________________ RN **School** ____________

TO BE COMPLETED BY PHYSICIAN

______________________ has had an anaphylactic incident:

☐ from a sting by ______________________ Date ____________

☐ after ingesting ______________________ Date ____________

☐ after exposure to ______________________ Date ____________

SYMPTOMS of the student's anaphylactic reaction included:

☐ hives spreading over the body

☐ wheezing

☐ difficulty swallowing / breathing

☐ swelling of lips, face, or neck

☐ tingling and swelling of tongue

☐ nausea / vomiting

☐ signs of shock (extreme pallor of flushing; clammy skin; rapid, weak pulse)

☐ loss of consciousness

☐ Other

____

____

MEDICATION given at the time of the incident:

☐ Epi Pen ☐ Epi Pen Jr. ☐ other form of adrenaline: ____________

____

☐ Epi Pen has been prescribed for precautionary purposes.

COMMENTS

____

____

Physician ______________________

Date ______________________ **Telephone** ____________