



Name: _____ School: _____ DOB: ____ / ____ / ____

Severity Classification: Intermittent Mild Persistent Moderate Persistent Severe Persistent

Asthma Triggers (list): _____

Date Completed: ____ / ____ / ____ Vaccinations updated: Yes No



Green Zone: Doing Well

Symptoms: Breathing is good – No cough or wheeze – Can work and play – Sleep well at night

Control Medicine(s)	Medicine	How much to take	When and how often to take it	Take at
	_____	_____	_____	<input type="checkbox"/> Home <input type="checkbox"/> School
Quick Relief Medicine(s)	_____	_____	_____	<input type="checkbox"/> Home <input type="checkbox"/> School
SMART/MART	<input type="checkbox"/> ICS/Formoterol _____ puff(s) with spacer _____ (daily max dose 12 puffs for ages 12+ yrs & 8 puffs for ages 4-11 yrs)			
Exercise Induced	<input type="checkbox"/> Use quick-relief medicine 10 minutes before physical activity as instructed			



Yellow Zone: Caution

Symptoms: Some problems breathing – Cough, wheeze, or tight chest – Problems working or playing – Wake at night

	Medicine	How much to take	When and how often to take it
Quick-relief Medicine(s)	<input type="checkbox"/> _____	_____	_____ <i>every 20 minutes for up to 1 hour OR Nebulizer (use once)</i>
Control Medicine(s)	<input type="checkbox"/> Continue Green Zone medicines		
SMART as quick reliever	<input type="checkbox"/> ICS/Formoterol _____ puff(s) with spacer _____ (daily max dose 12 puffs for ages 12+ yrs & 8 puffs for ages 4-11 yrs)		
Other	<input type="checkbox"/> _____		

You should feel better within 20–60 minutes of the quick-relief treatment. If you are getting worse THEN follow the instructions in the RED ZONE and call your doctor or 911 right away!



Red Zone: Get Help Now!

Symptoms: Lots of problems breathing – Cannot work or play – Getting worse instead of better – Medicine is not helping – I feel very sick

Take Quick-relief Medicine NOW!

	Medicine	How much to take	When and how often to take it
	<input type="checkbox"/> _____	_____ (puffs)	_____
SMART as quick reliever	<input type="checkbox"/> ICS/Formoterol _____ puff(s) with spacer _____		
Other	<input type="checkbox"/> _____		

Call 911 immediately if the following danger signs are present:

- Trouble walking/talking due to shortness of breath
- Lips or fingernails are blue
- Still in the red zone after 15 minutes

Parent/Guardian

- I give permission for the medicines listed in the action plan to be administered in school by the nurse or designated trained staff.
- I consent to communication between the prescribing health care provider or clinic, the school nurse, the school medical advisor or school-based health clinic providers necessary for asthma management and administration of this medicine.

Name _____ Date _____ Phone (____) ____ - _____ Signature _____

Healthcare Provider

Name _____ Date _____ Phone (____) ____ - _____ Signature _____

Healthcare Provider

- Both the Healthcare Provider and the Parent/Guardian feel that the child has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

Name _____ Date _____ Phone (____) ____ - _____ Signature _____

ROXBURY TOWNSHIP PUBLIC SCHOOLS

Succasunna, NJ

Medication Policy

Effective June 2020, Roxbury Township Board of Education adopted revised Policy #[5330](#) regarding the administration of medication to students. According to the policy, "medication" means any prescribed or over-the-counter medicine. This includes such medications as Tylenol, aspirin or cough drops.

The following guidelines **must** be followed when the administration of medication in school is necessary:

1. The parent or guardian **and** private physician must provide a written request for the administration of the prescribed medication at school. The physician's written order must include the following:
 - a. Name of the student
 - b. Diagnosis or type of illness involved
 - c. Name of the medication
 - d. Dosage
 - e. Time of administration
 - f. Time when its use will be discontinued
 - g. Side effects
2. Currently dated **medication must be brought to the Health Office by the parent/guardian in the original labeled container.** Most pharmacies will provide you with an extra bottle properly labeled for school.
3. Medication no longer required must be promptly removed by the parent/guardian.
4. Medication will only be administered to students in school by the school physician, a certified or non-certified school nurse, a substitute school nurse employed by the district or the student's parent/guardian. Students with asthma or other potentially life threatening illnesses will be allowed to self-administer medication when a nurse is not physically present at the scene. Permission for such administration must be on file in the office of the school nurse and comply with the conditions for granting permission.

Medication permission slips may be obtained from your school nurse or on-line at www.roxbury.org/Page/749.

Thank you for your attention to this matter.

ROXBURY SCHOOL DISTRICT | **Medication Administration Daily Log** (to be completed for each medication)

v.20231211

School Year 20 / 20 Student's School (Underline/Circle) → RHS EMS L/R Franklin Jefferson Kennedy Nixon

Name of Student _____ Date of Birth _____ Sex _____ Grade/Teacher _____

Parent/Guardian's signature granting permission for administration of medication/sharing of information with appropriate staff members:

Name of Parent/Guardian _____ Signature of Parent/Guardian _____ Date _____

Name & Dosage of Medication _____ Route _____ Time(s) Given in School _____

Start Date _____ End Date _____ (Medication must be in the original container as dispensed by the pharmacy or physician)

Reason for medication _____

Physician's Printed Name _____

Physician's signature _____ Date _____

Office Stamp of Physician →
or Attach Official Letter-head of Physician

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Aug																															
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Feb																															
Mar																															
Apr																															
May																															
Jun																															

- Initial & Signature of Person administering medication _____ Codes^ _____ ^See reverse side for reporting significant information.
1. _____ (A) Absent _____
 2. _____ (O) No Show _____
 3. _____ (W) Dosage Withheld _____
 4. _____ (N) No Medication Available _____
 - _____ (E) Early Dismissal _____
 - _____ (F) Field Trip _____
 - _____ (X) No School (e.g. Holiday; Weekend; Snow Day; etc.) _____

This permission form is effective only for the school year for which it is granted and must be renewed each school year.

ROXBURY SCHOOL DISTRICT | Permission for Self-Administration of Medication for Potentially Life-Threatening Illness

v.2025/06/13-1015

School Year 20 / 20 Student's School (Underline/Circle)→ RHS EMS L/R

Name of Student _____ Date of Birth _____ Sex _____ Grade/Teacher _____

Name of Medication _____

Dosage of Medication _____

Guidelines for Administration (Please be specific) _____

Possible Side Effects _____

Start Date _____ End Date _____ *(Medication must be in the original container as dispensed by the pharmacy or physician)*

I certify _____ suffers from a potentially life-threatening illness _____ *(Condition)*

and: ■ is capable of, and has been instructed in, the proper method of self-administration of the above stated medication; ■ is physically fit to attend school and is free of contagious disease; and ■ the medication must be administered during the school day or the student would not be able to attend school.

Physician's Printed Name _____

Physician's signature _____ Date _____

*Office Stamp of
Physician →
or Attach Official
Letter-head of
Physician*

Parent/Guardian's signature granting permission for self-administration of medication/sharing of information with appropriate staff members:

I hereby give consent for the disclosure of the information contained in the Action Plan for my student for the above described Potentially Life-Threatening Illness to all staff who may be involved in the implementation of the plan and to other appropriate staff. I acknowledge that the school 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 school district, the Board, and its employees or agents against any claims arising out of the self-administration of medication by my child.

I give permission for _____ *(Student's Name)* to self-administer _____ *(Medication)* as prescribed by his/her physician.

Name of Parent/Guardian _____ **Signature of Parent/Guardian** _____ Date _____

This permission form is effective only for the school year for which it is granted and must be renewed each school year.