

How to Use a Metered-Dose Inhaler with a Valved Holding Chamber (Spacer)

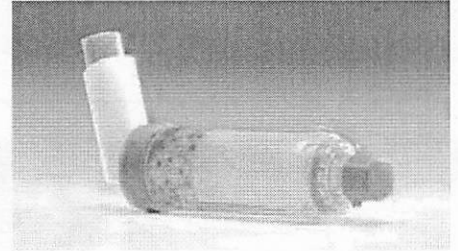
Prime a brand-new inhaler: Before using it for the first time, if you have not used it for more than 7 days, or if it has been dropped.



1. Shake inhaler 10 seconds.



2. Take the cap off the inhaler and valved holding chamber. Make sure the mouthpiece and valved holding chamber are clean and there is nothing inside the mouthpieces.



3. Put inhaler into the chamber/spacer.



4. Breathe out away from the device.



5. Put chamber mouthpiece in mouth.

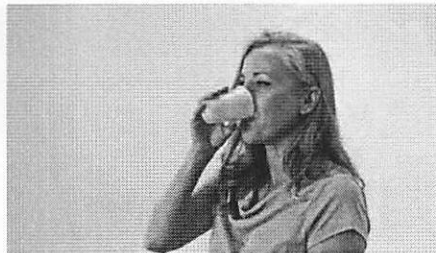


6. Press inhaler once and breathe in deep and steadily.



7. Hold your breath for 10 seconds, then breathe out slowly.

If you need another puff of medicine, wait 1 minute and repeat steps 4-7.



8. Rinse with water and spit it out.



Scan the QR Code to view
Asthma and COPD Medicines

For more asthma videos, handouts, tutorials and resources, visit [Lung.org/asthma](https://www.lung.org/asthma).

You can also connect with a respiratory therapist for one-on-one, free support the American Lung Association's Lung HelpLine at **1-800-LUNGUSA**.



My Asthma Action Plan



Scan the QR Code
to access How-To Videos

Name: _____ 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
Quick Relief Medicine(s)	_____	_____	_____
SMART/MART	☐ ICS/Formoterol _____ puff(s) with spacer _____ (daily max dose 12 puffs for ages 12+ yrs & 8 puffs for ages 4-11 yrs)		
Exercise Induced	☐ 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)	☐ _____	_____	_____
Control Medicine(s)	☐ Continue Green Zone medicines		every 20 minutes for up to 1 hour OR Nebulizer (use once)
SMART as quick reliever	☐ ICS/Formoterol _____ puff(s) with spacer _____ (daily max dose 12 puffs for ages 12+ yrs & 8 puffs for ages 4-11 yrs)		
Other	☐ _____	_____	_____

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
	☐ _____	_____ (puffs)	_____
SMART as quick reliever	☐ ICS/Formoterol _____	_____ puff(s) with spacer	_____
Other	☐ _____	_____	_____

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

Emergency Contact Name _____ Phone (____) _____ - _____

Emergency Contact Name _____ Phone (____) _____ - _____

1-800-LUNGUSA | Lung.org

**I. DOCTOR'S REQUEST/INSTRUCTIONS FOR MEDICINE TO BE GIVEN BY SCHOOL NURSE.
TO BE FILLED OUT BY PHYSICIAN**

⁵The 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



Office of the Nurse

TENAFLY HIGH SCHOOL
19 Columbus Drive
Tenaflly, 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 Tenaflly 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



500 Tenaflly Road, Tenaflly, 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 PHYSICIAN.

Sincerely,

A handwritten signature in black ink, appearing to read 'R. Shamim', written over a horizontal line.

Dr. Rehan Shamim
School Physician

/ss
Medication Policy