EMPOWERMENT ACADEMY CHARTER SCHOOL

240 Ege Ave
Jersey City, NJ 07304
Phone: (201) 630-4798
Fax: 201-333-5429

211 Sherman Ave.
Jersey City, NJ 07307
Phone: (201) 975-4299

School Website: www.empacad.org

Food Allergens/Asthma

To be completed by Parent and/or Guardian

Date: _____

Dear Parents/Guardians,

Please be advised that the Empowerment Academy Charter School is very concerned about the health and well-being of our scholars. We are always working in a proactive mode. One of our concerns is food allergens (for example, peanut products: peanut butter, almonds, etc.). It is imperative that we think Win-Win. This positive attitude will ensure scholars, parents and staff win. At the Empowerment Academy Charter School, we would like to know if your scholar/scholars have any food allergies that may cause any serious life-threatening illness.

Name of Scholar: _____
Grade: _____
Teacher: _____

Please check all items that apply:

Special Diet: ☐ Vegan ☐ Vegetarian ☐ No Beef ☐ No Pork ☐ No Wheat ☐ No Gluten

My scholar is allergic to or has food allergies to:

☐ Peanut Products ☐ Soybeans ☐ Fish/Shell mix ☐ Egg whole ☐ Dairy
☐Other (Please list): _____

My scholar has:

☐ Asthma ☐ Bronchitis ☐Other (Please list): _____
☐None. My scholar does not suffer from any known allergies

Also, please note if your scholar requires an Inhaler for Asthma or an Epipen (Epinephrine Auto Injector) for allergies, you must supply the school with doctor's orders as well as Inhaler and/or Epipen to be used in school and on field trips.

My scholar requires an Inhaler ☐ Yes No ☐ My scholar requires an EpiPen ☐ Yes No ☐
On field trips my scholar must take his/her Inhaler ☐ Yes No ☐ Epipen ☐ Yes No ☐

Please complete and return this form to E.A.C.S School Nurse immediately.

Parent/Guardian Signature: _____ **Emergency Contact Number:** _____

Sincerely,

Henrietta Johnson

Henrietta Johnson, Head Nurse, RN, BSN, MS, C.S.N-N.J.
School Nurse, EAC: LES 201-630-4798 Ext. 1008

Definitions of Vegan and Vegetarian

Definition of Veganism

Veganism is a way of living which seeks to exclude, as far as is possible and practicable, all forms of exploitation of, and cruelty to, animals for food, clothing or any other purpose. Vegans have in common a plant-based diet avoiding all animal foods such as meat (including fish, shellfish and insects), dairy, eggs and honey - as well as products like leather and any tested on animals.

Source: https://www.vegansociety.com/go-vegan/definition-veganism

Vegan

noun

Definition of *vegan*

: a strict vegetarian who consumes no food (such as meat, eggs, or dairy products) that comes from animals also
: one who abstains from using animal products (such as leather)

Source: https://www.merriam-webster.com/dictionary/vegan

Definition of Vegetarian

"A vegetarian is someone who lives on a diet of grains, pulses, legumes, nuts, seeds, vegetables, fruits, fungi, algae, yeast and/or some other non-animal-based foods (e.g. salt) with, or without, dairy products, honey and/or eggs. A vegetarian does not eat foods that consist of, or have been produced with the aid of products consisting of or created from, any part of the body of a living or dead animal. This includes meat, poultry, fish, shellfish*, insects, by-products of slaughter** or any food made with processing aids created from these."

Source: https://www.vegsoc.org/page.aspx?pid=508

Vegetarian

noun

Definition of *vegetarian*

: a person who does not eat meat : someone whose diet consists wholly of vegetables, fruits, grains, nuts, and sometimes eggs or dairy products
: herbivore

Source: https://www.merriam-webster.com/dictionary/vegetarian

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YEARLY STUDENT HEALTH INFORMATION UPDATE

Scholars Name: _____ Date of Birth: _____ Grade: _____
Address: _____ Health Insurance: _____
Contact Number:_____ Primary Physician:_____

Has your scholar received any immunizations or booster shots in the past year? ☐YES ☐NO
If YES, please bring a copy of the updated immunization record to the school.

In the past year, has your scholar had any outside evaluation such as medical, neurological, orthopedic, psychiatric, psychological, speech and language or any special test? ☐YES ☐NO

If YES, what is the type of evaluation and when is the follow-up appointment?_____

Last Physical Examination Date: _____ Examiner: _____
Last Dental Examination Date: _____ Examiner: _____

Has your scholar had or has any of the following? (Please check all that apply)

( ) High blood pressure
( ) Heart condition or murmur
( ) Asthma
( ) Severe allergies
( ) Contact with or history of tuberculosis
( ) Positive tuberculosis test
( ) Tumor growth or cancer
( ) Chest pain (when exercising)
( ) Diabetes
( ) Serious skin disease
( ) Head injury
( ) Frequent or severe headache
( ) Dizziness or faint spells
( ) Epilepsy/seizures/convulsions
( ) Frequent nose bleeding
( ) Excessive worry or anxiety
( ) Depression
( ) Ulcer
( ) Severe or chronic abdominal pain
( ) Excessive colds
( ) Speech problem
( ) Eye trouble
( ) Wear glasses
( ) Frequent ear infections
( ) Loss of hearing
( ) Frequent or painful urination
( ) Inability to hold urine
( ) Intestinal trouble
( ) Scoliosis or family history of scoliosis
( ) Step throat infections

Has your scholar had any operations or bone problems? ☐YES ☐ NO
If Yes, please indicate what type of operation and when _____

Has your scholar ever had any serious illnesses or injuries other than those already noted above? ☐YES ☐ NO
If Yes, please indicate what type of illness or injury and when_____

Has your scholar been diagnosed with Attention Deficit Hyperactivity Disorder? ☐ YES ☐ NO
If YES, please indicate when your scholar was diagnosed and the medications that are currently being taken.

_____
_____
_____
_____

Is your scholar allergic to (please check all that apply):
( ) Bee sting ( ) Milk
( ) Chocolates ( ) Fruit- if YES, what type? _____
( ) Peanuts ( ) Medicine- If YES, what type_____
( ) Other types of allergy, please indicate. _____

If you scholar has severe allergies please coordinate with the School Nurse for any medications needed to be administered during school in case of an emergency.

Does your scholar have asthma? ☐YES ☐NO
If YES, is your scholar under treatment? What type of medication and frequency?

_____
If your scholar needs asthma treatment to be administered in the school, please contact the School Nurse.

Does your scholar have other health/behavioral problems such as learning, hyperactivity, tantrums, or coordination? ☐YES ☐NO
If YES, is your scholar under regular medical supervision? ☐YES ☐NO
Name of physician: _____

Current medication (s) being taken: _____
_____
If your scholar needs to take medication at school, please coordinate with the School Nurse.

If there are any questions or concerns about your scholar 's health please contact the school at (201) 630-4798, ext. 1008.

Please be assured that any information given out on this form will be used confidentially in meeting your scholar 's health and educational needs in school. Please return this form to the teacher as soon as possible.

Parent/Guardian Name (Please Print): _____

Parent/Guardian Signature (Please Print): _____

Date: _____

Contact Number: _____

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ADMINISTRATION OF MEDICATION IN SCHOOL

Before any medications, including over the counter, can be administered to your scholar at school the following guidelines are required and must be met:

Parent/Guardians please read and sign at the bottom of this form.

1. The prescribing physician or nurse practitioner must sign the doctor's order form called "Authorization of Medications to be Taken during School Hours" to include the medical diagnosis, name of the medication, dosage, route time and frequency, duration, side effects, and if the scholar is authorized to medicate herself/himself with nurse/teacher's supervision. These doctor's orders are only good for one academic school year which is September to June and must be renewed every September of each year no exception.

2. The parent/guardian must also sign this medication consent form to request that your scholar be assisted in taking medication(s) during school hours and giving the school nurse permission to administer prescribed medications to your scholar relieves the board and its employees of liability for the administration of such medication.

3. All medication including over the counter shall be bought to school by parent/guardian. Children are not allowed to carry medication to school (except for Inhalers or Epipen). It can be dangerous and cause many problems involving other children. The Inhaler/Asthma pumps, Epipen must be pre-approved by a Medical Doctor for the student to self-medicate himself or herself. Scholars must not share their medications with other scholars.

4. Medications should be brought to school in the original container, unopened and sealed, appropriately labeled by the pharmacy with the child's name to prevent loss and to prevent giving the wrong medication to the wrong student. **Please note: Any open medication will not be accepted by the school nurse. If medication is a partial dose (1/2 tablet), please make sure all medication is cut in half by the pharmacy before giving medication to the school nurse.**

5. The school will provide a secured, locked space for the safe storage of the medication. All prescription drugs are kept locked at all times.

6. The school nurse or parent/guardian is the only person permitted to administer medication at school. Exceptions: Only asthma Inhalers and Epipens are allowed for self-administration with the pre-approval of the child's doctor before the nurse/teacher can supervise the administration of medication.

7. The record of the administration of medication to your scholar will be kept and maintained by the school nurse.

8. At the end of the school year, all medications MUST be picked up on the last day of school in June by the parent if not it will be disposed of appropriately at end of the academic year.

If you have any questions, please give the school nurse a call at:
EAC: LES (201) 630-4798, ext. 1008 or EAC: UES (201) 975-4299

Parent/Guardian Signature: _____ **Date:** _____

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Request for Medication to be Taken during School Hours and Given by School Nurse

The following section is to be completed by Parent and/or Guardian:

School: EAC: ☐ LES ☐UES Grade: ___ Teacher: _____

Scholar's Name: _____ (Last) _____ (First) ☐M ☐F (Sex) _____ (D.O.B)

_____ (Health Care Provider's Name) _ _____ (Address) _____ (Telephone)

I give permission for the exchange of verbal and written communication between the physician and the school nurse regarding my scholar's medication regime. I request that my scholar be assisted in taking the medicine (s) describe below at school by authorized persons or permitted to medicate herself/himself as also authorized by me and my physician (see below).

___

_____ Date _____ Parent/Guardian Signature _____ Home Phone _____ Emergency Phone

The following is to be completed by the child's doctor.

Diagnosis for which medication is given:
Name of the medication:
Dosage, route, frequency, and time:
If medication is given DAILY, ☐ Y ☐ N At what time? _____ ☐ AM ☐ PM
If medicine to be given when NEEDED, describe indication:
How soon can it be repeated?
Is a scholar authorized to medicate Herself/himself? ☐ Y ☐ N
List significant side effects:
Length of time this treatment is Recommended:

Other Information:

_____
_____
_____
_____
_____

MD Stamp

MD Name (PRINT) _____ MD Signature_____ Date_____

APPENDIX H

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: *American Academy of Pediatrics, New Jersey Chapter*
New Jersey Academy of Family Physicians
New Jersey Department of Health

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name *(Last)* *(First)*	Gender ☐ Male ☐ Female	Date of Birth / /
Does Child Have Health Insurance? ☐Yes ☐No	If Yes, Name of Child's Health Insurance Carrier	
Parent/Guardian Name	Home Telephone Number ( ) -	Work Telephone/Cell Phone Number ( ) -
Parent/Guardian Name	Home Telephone Number ( ) -	Work Telephone/Cell Phone Number ( ) -

I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Signature/Date	This form may be released to WIC. ☐Yes ☐No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:	Results of physical examination normal? ☐Yes ☐No	
Abnormalities Noted:	Weight *(must be taken within 30 days for WIC)*	
	Height *(must be taken within 30 days for WIC)*	
	Head Circumference *(if <2 Years)*	
	Blood Pressure *(if ≥3 Years)*	

IMMUNIZATIONS	☐ Immunization Record Attached ☐ Date Next Immunization Due: _____

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐ None ☐ Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	☐ None ☐ Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☐ None ☐ Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐ None ☐ Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☐ None ☐ Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☐ None ☐ Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☐ None ☐ Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: ☐ Capillary ☐ Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

☐ ***I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.***

Name of Health Care Provider (Print)	Health Care Provider Stamp:
Signature/Date	

Instructions for Completing the Universal Child Health Record (CH-14)

Section 1 - Parent

Please have the parent/guardian complete the top section and sign the consent for the child care provider/school nurse to discuss any information on this form with the health care provider.

The WIC box needs to be checked only if this form is being sent to the WIC office. WIC is a supplemental nutrition program for Women, Infants and Children that provides nutritious foods, nutrition counseling, health care referrals and breast feeding support to income eligible families. For more information about WIC in your area call 1-800-328-3838.

Section 2 - Health Care Provider

1. Please enter the date of the physical exam that is being used to complete the form. Note significant abnormalities especially if the child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing etc.)
   - **Weight** - Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within the last 30 days.
   - **Height** - Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within the last 30 days.
   - **Head Circumference** - Only enter if the child is less than 2 years.
   - **Blood Pressure** - Only enter if the child is 3 years or older.

2. **Immunization** - A copy of an immunization record may be copied and attached. If you need a blank form on which to enter the immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Department of Health, Vaccine Preventable Diseases Program at 609-826-4860. The Immunization record must be attached for the form to be valid.
   - "Date next immunization is due" is optional but helps child care providers to assure that children in their care are up-to-date with immunizations.

3. **Medical Conditions** - Please list any ongoing medical conditions that might impact the child's health and well being in the child care or school setting.

   a. Note any significant medical conditions or major surgical history. **If the child has a complex medical condition, a special care plan should be completed and attached for any of the medical issue blocks that follow.** A generic care plan (CH-15) can be downloaded at www.nj.gov/health/forms/ch-15.dot or pdf. Hard copies of the CH-15 can be requested from the Division of Family Health Services at 609-292-5666.

   b. **Medications** - List any ongoing medications. Include any medications given at home if they might impact the child's health while in child care (seizure, cardiac or asthma medications, etc.). Short-term medications such as antibiotics do not need to be listed on this form. Long-term antibiotics such as antibiotics for urinary tract infections or sickle cell prophylaxis should be included.

      PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigger medication administration. *Please be specific about what over-the-counter (OTC) medications you recommend, and include information for the parent and child care provider as to dosage, route, frequency, and possible side effects. Many child care providers may require separate permissions slips for prescription and OTC medications.*

   c. **Limitations to physical activity** - Please be as specific as possible and include dates of limitation as appropriate. Any limitation to field trips should be noted. Note any special considerations such as avoiding sun exposure or exposure to allergens. Potential severe reaction to insect stings should be noted. Special considerations such as back-only sleeping for infants should be noted.

   d. **Special Equipment** – Enter if the child wears glasses, orthodontic devices, orthotics, or other special equipment. Children with complex equipment needs should have a care plan.

   e. **Allergies/Sensitivities** - Children with life-threatening allergies should have a special care plan. Severe allergic reactions to animals or foods (wheezing etc.) should be noted. Pediatric asthma action plans can be obtained from The Pediatric Asthma Coalition of New Jersey at www.pacnj.org or by phone at 908-687-9340.

   f. **Special Diets** - Any special diet and/or supplements that are medically indicated should be included. Exclusive breastfeeding should be noted.

   g. **Behavioral/Mental Health issues** – Please note any significant behavioral problems or mental health diagnoses such as autism, breath holding, or ADHD.

   h. **Emergency Plans** - May require a special care plan if interventions are complex. Be specific about signs and symptoms to watch for. Use simple language and avoid the use of complex medical terms.

4. **Screening** - This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public heath personnel to track children's health. Please enter the date that the test was performed. Note if the test was abnormal or place an "N" if it was normal.
   - For lead screening state if the blood sample was capillary or venous and the value of the test performed.
   - For PPD enter millimeters of induration, and the date listed should be the date read. If a chest x-ray was done, record results.
   - Scoliosis screenings are done biennially in the public schools beginning at age 10.

   This form may be used for clearance for sports or physical education. As such, please check the box above the signature line and make any appropriate notations in the Limitation to Physical Activities block.

5. Please sign and date the form with the date the form was completed (note the date of the exam, if different)
   - Print the health care provider's name.
   - Stamp with health care site's name, address and phone number.

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLA

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ **No**

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Shortness of breath, wheezing, repetitive cough

HEART
Pale or bluish skin, faintness, weak pulse, dizziness

THROAT
Tight or hoarse throat, trouble breathing or swallowing

MOUTH
Significant swelling of the tongue or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy or runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

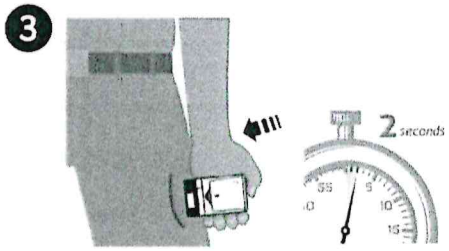
_____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

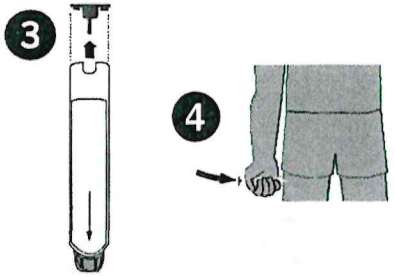
HOW TO USE AUVI-Q® (EPINEPRHINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
5. Call 911 and get emergency medical help right away.



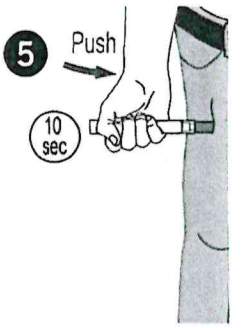
HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, IMPAX LABORATORIES

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip.
3. Grasp the auto-injector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. Call 911 and get emergency medical help right away.



ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

TO BE COMPLETED BY DOCTOR IF APPLICABL

Asthma Treatment Plan – Student

(This asthma action plan meets NJ Law N.J.S.A. 18A:40-12.8) (Physician's Orders)

The Pediatric/Adult Asthma Coalition of New Jersey
"Your Pathway to Asthma Control"
PACNJ approved Plan available at www.pacnj.org

Sponsored by AMERICAN LUNG ASSOCIATION. IN NEW JERSEY

NJ Health New Jersey Department of Health

(Please Print)

Name		Date of Birth	Effective Date
Doctor	Parent/Guardian (if applicable)	Emergency Contact	
Phone	Phone	Phone	

HEALTHY (Green Zone)

Take daily control medicine(s). Some inhalers may be more effective with a "spacer" – use if directed.

You have *all* of these:

- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work, exercise, and play

And/or Peak flow above ________

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Advair® HFA ☐ 45, ☐ 115, ☐ 230	2 puffs twice a day
☐ Aerospan™	☐ 1, ☐ 2 puffs twice a day
☐ Alvesco® ☐ 80, ☐ 160	☐ 1, ☐ 2 puffs twice a day
☐ Dulera® ☐ 100, ☐ 200	2 puffs twice a day
☐ Flovent® ☐ 44, ☐ 110, ☐ 220	2 puffs twice a day
☐ Qvar® ☐ 40, ☐ 80	☐ 1, ☐ 2 puffs twice a day
☐ Symbicort® ☐ 80, ☐ 160	☐ 1, ☐ 2 puffs twice a day
☐ Advair Diskus® ☐ 100, ☐ 250, ☐ 500	1 inhalation twice a day
☐ Asmanex® Twisthaler® ☐ 110, ☐ 220	☐ 1, ☐ 2 inhalations ☐ once or ☐ twice a day
☐ Flovent® Diskus® ☐ 50 ☐ 100 ☐ 250	1 inhalation twice a day
☐ Pulmicort Flexhaler® ☐ 90, ☐ 180	☐ 1, ☐ 2 inhalations ☐ once or ☐ twice a day
☐ Pulmicort Respules® (Budesonide) ☐ 0.25, ☐ 0.5, ☐ 1.0	1 unit nebulized ☐ once or ☐ twice a day
☐ Singulair® (Montelukast) ☐ 4, ☐ 5, ☐ 10 mg	1 tablet daily
☐ Other	
☐ None	

Remember to rinse your mouth after taking inhaled medicine.

If exercise triggers your asthma, take__________________ ____ puff(s) ____minutes before exercise.

CAUTION (Yellow Zone)

Continue daily control medicine(s) and ADD quick-relief medicine(s).

You have *any* of these:

- Cough
- Mild wheeze
- Tight chest
- Coughing at night
- Other:__________

If quick-relief medicine does not help within 15-20 minutes or has been used more than 2 times and symptoms persist, call your doctor or go to the emergency room.

And/or Peak flow from______ to______

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	2 puffs every 4 hours as needed
☐ Xopenex®	2 puffs every 4 hours as needed
☐ Albuterol ☐ 1.25, ☐ 2.5 mg	1 unit nebulized every 4 hours as needed
☐ Duoneb®	1 unit nebulized every 4 hours as needed
☐ Xopenex® (Levalbuterol) ☐ 0.31, ☐ 0.63, ☐ 1.25 mg	1 unit nebulized every 4 hours as needed
☐ Combivent Respimat®	1 inhalation 4 times a day
☐ Increase the dose of, or add:	
☐ Other	

- **If quick-relief medicine is needed more than 2 times a week, except before exercise, then call your doctor.**

EMERGENCY (Red Zone)

Take these medicines NOW and CALL 911.
Asthma can be a life-threatening illness. Do not wait!

Your asthma is getting worse fast:

- Quick-relief medicine did not help within 15-20 minutes
- Breathing is hard or fast
- Nose opens wide • Ribs show
- Trouble walking and talking
- Lips blue • Fingernails blue
- Other:__________

And/or Peak flow below ________

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	4 puffs every 20 minutes
☐ Xopenex®	4 puffs every 20 minutes
☐ Albuterol ☐ 1.25, ☐ 2.5 mg	1 unit nebulized every 20 minutes
☐ Duoneb®	1 unit nebulized every 20 minutes
☐ Xopenex® (Levalbuterol) ☐ 0.31, ☐ 0.63, ☐ 1.25 mg	1 unit nebulized every 20 minutes
☐ Combivent Respimat®	1 inhalation 4 times a day
☐ Other	

Triggers

Check all items that trigger patient's asthma:

- ☐ Colds/flu
- ☐ Exercise
- ☐ Allergens
  - ○ Dust Mites, dust, stuffed animals, carpet
  - ○ Pollen - trees, grass, weeds
  - ○ Mold
  - ○ Pets - animal dander
  - ○ Pests - rodents, cockroaches
- ☐ Odors (Irritants)
  - ○ Cigarette smoke & second hand smoke
  - ○ Perfumes, cleaning products, scented products
  - ○ Smoke from burning wood, inside or outside
- ☐ Weather
  - ○ Sudden temperature change
  - ○ Extreme weather - hot and cold
  - ○ Ozone alert days
- ☐ Foods:
  - ○ ________
  - ○ ________
  - ○ ________
- ☐ Other:
  - ○ ________
  - ○ ________
  - ○ ________

This asthma treatment plan is meant to assist, not replace, the clinical decision-making required to meet individual patient needs

REVISED AUGUST 2014

Permission to Self-administer Medication:

☐ This student is capable and has been instructed in the proper method of self-administering of the non-nebulized inhaled medications named above in accordance with NJ Law.

☐ This student is not approved to self-medicate.

PHYSICIAN/APN/PA SIGNATURE________________________ DATE________

Physician's Orders

PARENT/GUARDIAN SIGNATURE________________________

PHYSICIAN STAMP

Make a copy for parent and for physician file, send original to school nurse or child care provider.

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 date of birth
   - Child's doctor's name & phone number
   - An Emergency Contact person's name & phone number
   - Parent/Guardian'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 _____

The Pediatric/Adult Asthma Coalition of New Jersey

"Your Pathway to Asthma Control"
PACNJ approved Plan available at www.pacnj.org

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