Carole Orthmann
School Nurse

ORADELL PUBLIC SCHOOL
Nurse's Office

350 Prospect Avenue
Oradell, New Jersey 07649
Phone: 201-261-1180 ext 4121 Fax: 201-634-1412

June 2017

Re: Nurse's Office Medication Paperwork for Students Entering Pre-K to 6th Grade for the 2017-18 School Year

Dear Parent/Guardian,

Attached are the forms and paperwork required to be completed for students in grades **Pre-K to sixth grade** in September 2017.

This packet of information includes the following:

- Medication Form Checklist
- Asthma Treatment Plan – Student
- Food Allergy & Anaphylaxis Emergency Care Plan
- 2017-2018 Allergy Questionnaire
- Authorization for Medication to be Given in School and
- Epi-Pen Authorization

Please return the new paperwork and medication to the Nurse's Office on the first day of school.

If you have any questions, please call me.

Thank you,

Carole Orthmann, RN

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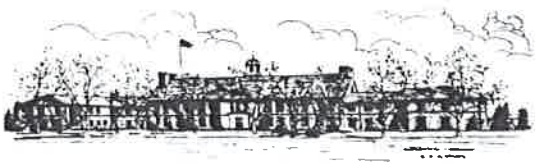

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Medication Form Checklist

June 2017

The following forms are to be filled out by your doctor:

☐ Asthma Treatment Plan – Please attach a current photo of your child to this form.

☐ Food or Allergy Action Plan – This form is regarding allergies. Please attach current photo of your child to this form.

☐ Allergy Questionnaire

The following forms are to be filled out by the parent/guardian:

☐ Medical Authorization Form – This gives permission for medication to be given at school.

☐ Epipen Authorization Form

These forms need to be dated for the 2017-2018 school year.

The medication(s) and forms should be given to me on the first day of school.

Please see the nurse to obtain a form for self-administration of medication by students at school.

If you have any questions, please call me.

Thank you,

Carole Orthmann, RN

Carole Orthmann, RN
School Nurse

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" — www.pacnj.org

Sponsored by American Lung Association in New Jersey

NJ Health

(Please Print)

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

HEALTHY (Green Zone)

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 _____

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

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)

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_____

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

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)

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 _____

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

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.

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"
Additional Plans available at www.pacnj.org

Sponsored by
AMERICAN LUNG ASSOCIATION. OF NEW JERSEY

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

Name: _____ D.O.B.: _____

Allergy to: _____

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

PLACE PICTURE HERE

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

Extremely reactive to the following foods: _____

THEREFORE:

[ ] If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

[ ] If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Short of breath, wheezing, repetitive cough

HEART
Pale, blue, faint, weak pulse, dizzy

THROAT
Tight, hoarse, trouble breathing/ swallowing

MOUTH
Significant swelling of the tongue and/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 them the child is having anaphylaxis and may need epinephrine when they 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 them to ER even if symptoms resolve. Person should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/ 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: _____

Epinephrine Dose: [ ] 0.15 mg IM [ ] 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

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

_____

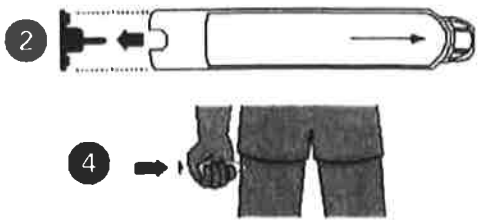
PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 5/2014

FARE FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

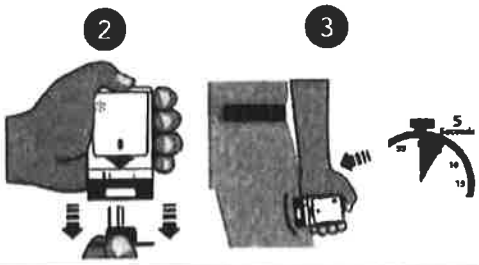
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



ADRENACLICK®/ADRENACLICK® GENERIC DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.

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 get worse quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 5/2014

Mr. Brian Mistretta
Director of Special Services

Carole Orthmann, RN
School Nurse
201-261-1180 Ext. 4121
201-634-1412 FAX

ORADELL PUBLIC SCHOOL
350 Prospect Avenue
Oradell, NJ 07649

Allergy Questionnaire
2017-2018 School Year

Child's Name:_____ **Date of Birth:**_____ **Grade:**____

What is your child allergic to? Is the allergy from eating only or is contact, touching, or smelling a concern?

Describe the reaction your child had (i.e., rash, itching, swelling, cough, trouble breathing, nausea).

Has your child been tested for allergies? List the allergens he/she is positive for.

When did your child have the last allergic reaction? To what was it attributed?

How was it treated? Medications given? Was a hospital visit needed?

Did your child have an anaphylactic incident? Please list the symptoms.

Please list the medications your child is presently taking. Include over the counter meds.

Does your child have an Epinephrine auto-injector or Auvi Q? ☐ **YES** ☐ **NO**

☐ **My child needs to sit at the nut free table**

☐ **My child does not need to sit at the nut free table**

Parent Signature_____ ***Date***_____

****Please attach lab results with allergy levels***

Mr. Brian Mistretta
Director of Special Services

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AUTHORIZATION FOR MEDICATION TO BE GIVEN IN SCHOOL

Student Name:_____ **Date:**_____

Grade/Teacher:_____ **School Year:**_____

Medication:_____ **Dose:**_____

Route:_____ **Time:**_____

Diagnosis:_____

Side Effects:_____

Family Physician:_____ **Phone:**_____

Physician Address:_____

***Physician Signature:**_____ **Date:**_____

PARENT

I give my permission for my child to be medicated by the school nurse according to my physician's instructions. I will notify the school immediately if my child's health status changes or there is a change or cancellation of the medication.

****Parent Signature**_____ **Date:**_____

SCHOOL PHYSICIAN:
I have reviewed the prescription and approve of it as written.

***School Physician Signature:**_____ **Date:**_____

Mr. Brian Mistretta
Director of Special Services

ORADELL PUBLIC SCHOOL
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Carole Orthmann, RN
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201-261-1180 Ext. 4121
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EPI-PEN AUTHORIZATION

To be completed by Parent/Guardian:

A current single dose Epinephrine auto-injector must be provided to the school for your child's use. All antihistamines and epinephrine must be brought to school by an adult and be provided in the original container.

Select one to sign and date:

☐ I verify that my child,_____, has a potentially life-threatening illness and **is unable to self-administer the prescribed** medication in a life threatening situation. **I hereby request the school nurse or delegate (if applicable) to administer the prescribed medication to my child.** I further acknowledge that the Oradell Public School District shall incur no liability as a result of any injury arising from administration of medication to my child. If procedures are specified by NJ law and Oradell Public School District Policy (additional paperwork must be obtained from the nurse and completed according to District Policy) are followed. I shall indemnify and hold harmless the Oradell Public School District and its employees or agents against any claims arising out of administration of medication to my child.

_____ _____
(Signature of Parent/Guardian) *(Date)*

☐ I verify that my child,_____, has a potentially life-threatening illness and **has been instructed in self-administration of the prescribed medication** in a life-threatening situation. **I hereby give permission for my child to self-administer prescribed medication.** I further acknowledge that the Oradell Public School District shall incur no liability as a result of any injuring arising from the self-administration of medication by my child. If procedures specified by NJ law and Oradell Public School District policy (additional paperwork must be obtained from the nurse and completed according to District policy) are followed, I shall indemnify and hold harmless the Oradell Pubic School District and its employees or agents against any claims arising out of self-administration of medication by my child. NJ State Assembly Act 2600 directs that students may be permitted to self-administer medication for asthma and potentially life-threatening illnesses or a life-threatening allergic reaction, provided proper procedures are followed.)

_____ _____
(Signature of Parent/Guardian) *(Date)*

SCHOOL USE ONLY:

Please sign:
I understand that under NJ State law, a **trained delegate will be assigned to administer epinephrine** to my child **in the absence of a school nurse.** Antihistamines may not be given by a delegate. In the absence of a school nurse, any antihistamine order will be disregarded and epinephrine will be administered by a trained delegate.

_____ _____
(Signature of Parent) *(Date)*

_____ _____
(Signature of Principal) *(Date)*