**John C. Anzul, Ed.D.** Superintendent

**Megan Bozios,** Principal

Oradell Public School District

350 Prospect Avenue | Oradell, NJ 07649 | oradellschool.org | (201)261-1180

*Our children,*
*our hope,*
*our future*

August 2019

Re: Nurse's Office Medication Paperwork for Students Entering Pre-K to 6th Grade for the 2019-2020 School Year

Dear Parent/Guardian,

Attached are the forms and paperwork required to be completed for students in grades Pre-K to 6th grade in September 2019.

This packet of information includes the following

- Medication Form Checklist
- Asthma Treatment Plan – Student
- Food Allergy & Anaphylaxis Emergency Care Plan
- 2019-2020 Allergy Questionnaire
- Authorization for Medication to be Given at School
- 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,

Gina Marana BSN, RN

School Nurse

Oradell Public School
201-261-1180 ext. 4121
Fax: 201-634-1412

# Medication Form Checklist

August 2019

**The following forms are to be completed 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 completed by the parent/guardian:**

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

These forms need to be dated for the 2019-2020 school year.

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

Please contact the nurse's office to obtain a form for self-administration of medication by students at school.

If you have any questions, please call me.

Thank you,

Gina Marana BSN, RN
School Nurse

Oradell Public School
201-261-1180 ext. 4121
Fax: 201-634-1412

# 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<br>Phone | Parent/Guardian (if applicable)<br>Phone | Emergency Contact<br>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

REVISED AUGUST 2014



**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



The Pediatric/Adult Asthma Coalition of New Jersey, sponsored by the American Lung Association in New Jersey. This publication was supported by a grant from the New Jersey Department of Health and Senior Services, with funds provided by the U.S. Centers for Disease Control and Prevention under Cooperative Agreement 5U59EH000491-5. Its content are solely the responsibility of the authors and do not necessarily represent the official views of the New Jersey Department of Health and Senior Services or the U.S. Centers for Disease Control and Prevention. Although this document has been funded wholly or in part by the United States Environmental Protection Agency under Agreement XA96296601-2 to the American Lung Association in New Jersey, it has not gone through the Agency's publications review process and therefore, may not necessarily reflect the views of the Agency and no official endorsement should be inferred. Information in this publication is not intended to diagnose health problems or take the place of medical advice. For asthma or any medical condition, seek medical advice from your child's or your health care professional.

*Sponsored by*
AMERICAN LUNG ASSOCIATION® IN 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**

**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

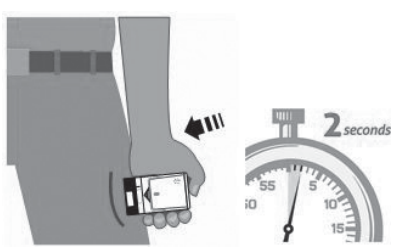
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2018

# FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

FARE
Food Allergy Research & Education

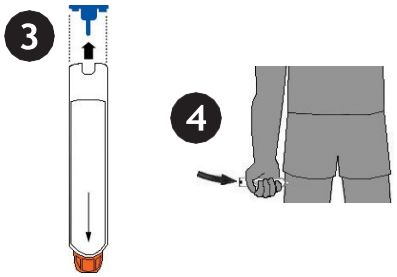
## HOW TO USE AUVI-Q® (EPINEPRHINE INJECTION, USP), KALEO

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.



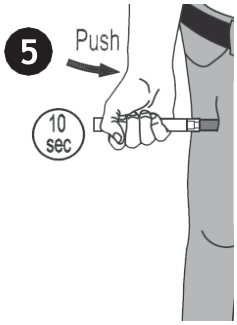

## HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

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: _____

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2018

# ORADELL PUBLIC SCHOOL
## 350 Prospect Avenue
## Oradell, NJ 07649

## *Allergy Questionnaire*
## *2019-2020 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***

**ORADELL PUBLIC SCHOOL**
**350 Prospect Avenue**
**Oradell, NJ 07649**

## 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:** _____

# ORADELL PUBLIC SCHOOL
## 350 Prospect Avenue
## Oradell, NJ 07649

## 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/Guardian)* *(Date)*

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