DEPAUL CATHOLIC
HIGH SCHOOL

1512 Alps Road, Wayne, NJ 07470-3695
973.694.3702 | Fax: 973.633.5381 | http://www.depaulcatholic.org

Dear Parent/Guardian:

In April 2001, State Law N.J.S.A. 18A:40-12.9 went into effect in New Jersey. This law requires an asthma action plan for all students diagnosed with asthma*. Since your child has a diagnosis of asthma, I've enclosed a copy of the asthma action plan and the necessary paperwork to be completed by both physician and parent. These forms will be used for this school year. Please fill out all the necessary information and return it to the school's health office within one week. This paperwork is required so that your child can be cared for properly and so that he/she may self-administer their inhaler in school.

*If this does not pertain to your child, please fill in only the second page and return it to our health office and no further paperwork from this packet is required.

If you have any concerns or questions please feel free to contact me at school 973-694-3702 x 270, Fax - 973-694-6232. Thank you for your anticipated cooperation with this matter.

Sincerely,
School Nurse

DEPAUL CATHOLIC
HIGH SCHOOL
1512 Alps Road, Wayne, NJ 07470-3695
973.694.3702 | Fax: 973.633.5381 | http://www.depaulcatholic.org

Dear Parent or Guardian,

If your child does not have asthma any longer or has never had it, please check off the appropriate box below and return this back to the school nurse. No further paperwork from this package is required.

Please call our office if you have any questions.

Sincerely,
School Nurse

Student's Name: _____ *Grade:* _____

- ☐ *My child no longer has asthma and he/she is no longer on any medications for asthma. Please make a note of this for your records.*
- ☐ *My child never had asthma. Please make a note of this for your records.*

Parent Name (Please print): _____ *Date:* _____

Parent Signature: _____

Other Comments: _____

4/8/16

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
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

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Advair® HFA ☐ 45, ☐ 115, ☐ 230 ________	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	

And/or Peak flow above ________

Remember to rinse your mouth after taking inhaled medicine.

If exercise triggers your asthma, take this medicine________________ ____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
☐ Combivent® ☐ Maxair® ☐ Xopenex® ________	2 puffs every 4 hours as needed
☐ Ventolin® ☐ Pro-Air® ☐ Proventil® ________	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
☐ 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
☐ Combivent® ☐ Maxair® ☐ Xopenex® ________	2 puffs every 20 minutes
☐ Ventolin® ☐ Pro-Air® ☐ Proventil® ________	2 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
☐ Other	

Triggers

Check all items that trigger patient's asthma:

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

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________

PARENT/GUARDIAN SIGNATURE____________________

PHYSICIAN STAMP

REVISED JULY 2012

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 _____

STUDENT AUTHORIZATION FOR SELF ADMINISTRATION OF ASTHMA MEDICATION
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 is 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 Cooperative Agreement #U58EH000981-10. Its contents 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 XA83255805-4 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

DE PAUL CATHOLIC
HIGH SCHOOL
1512 Alps Road, Wayne, NJ 07470-3695
973.694.3702 | Fax: 973.633.5381 | http://www.depaulcatholic.org

PERMISSION TO SHARE INFORMATION
20___-20___

As you are aware, everyday each of our students has contact with a variety of staff members: teachers, bus drivers, therapists, assistants, cafeteria workers, and student interns. While your child is in the care of these people, it is important that they are aware of any information that would require special considerations for his or her health and safety.

To comply with privacy laws, I am requesting your permission to share personal information about your child. This would consist of only that information deemed necessary to protect the well-being of your child. Examples of information that could be shared about your child may include: known allergies, special diets or food restriction, and a history of seizures. This may be done in the form of a printed list or verbal contact with those people who will be working closely with your child. If you have specific questions regarding your child, please call me at school. As always, please feel comfortable knowing that any information you do not want shared with anyone will be kept confidential. Thank you.

PLEASE COMPLETE, SIGN BELOW AND RETURN THIS FORM TO YOUR CHILD'S SCHOOL

Child's Name: _____

_____ **Yes**, I give permission for personal information about my child to be shared with other staff members if it will protect his/her health and safety.

_____ **No**, I do not give permission for personal information about my child to be shared with other staff members if it will protect his/her health and safety.

_____ _____
Parent/Guardian Signature Date

DE PAUL CATHOLIC HIGH SCHOOL 20___ - 20___
EMERGENCY INFORMATION CARD

Please Print Grade_____

Student's Name_____

Address_____ Home Tel._____

City _____ Birth Date _____

Where parents can be reached between 7:30 AM – 3 PM (work #):

Mother:_____ Tel.#1 _____
Tel #2_____
E-Mail _____

Father:_____ Tel.#1 _____
Tel #2_____
E-Mail _____

List two neighbors or nearby relatives who will assume temporary care of your child if you cannot be reached.

1. Name _____ Tel.#1 _____
   Tel #2_____
   Address _____ City_____
2. Name _____ Tel.#1_____
   Tel.#2_____
   Address_____ City_____

Date _____

In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated below and to follow his instructions. If it is impossible to contact this physician, the school may make whatever arrangements seem necessary.

Signature of parent or guardian _____

Remarks: _____

Allergies: _____

Other Conditions: _____

Local Physician's Name _____

Address _____City _____

Office Tel. No. _____ Other Tel No. _____