Green Brook Family Medicine

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FAMILY MEDICINE

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Dear Parent or Guardian:

New Jersey Law requires each Asthmatic Student in our school district to have an Individual Emergency Asthma Treatment Care Plan completed by your physician. This Treatment Plan will be utilized in the event your child has an asthma flare-up at school.

Please take this packet to your child's physician. Attached are forms regarding medication administration which are to be completed by yourself and your physician.

Dear Physician:

NJ state law states "that each student authorized to use asthma medication or a nebulizer pursuant to N.J.S.A. 18A:40-12.3, have an asthma treatment plan prepared by the student's physician, which shall identify at a minimum, asthma triggers and an individualized healthcare plan, pursuant to N.J.A.C. 6A:16-2.1(a), for meeting the medical needs of the student while attending school or a school-sponsored event.".

Your patient has been identified to be in need of an Individual Asthma Emergency Treatment Plan. In an effort to simplify the paperwork, I have developed an Asthma Treatment Plan for your review. This is an emergency care plan that will be utilized in the event your patient has an asthma flare-up while at school.
If you are interested in using this plan, please complete the appropriate sections and return the form. If this plan is not acceptable, please submit an alternate plan which contains information regarding known asthmatic triggers, current medication and emergency treatment instructions.

In addition, please complete the: *AUTHORIZATION FOR ADMINISTRATION OF ASTHMA PRESCRIPTION MEDICATION* Form.

If you have any questions, please contact me at my office.

Sincerely,

Ronald M Frank, MD FAAFP
School Medical Inspector

Individual Asthma Emergency Treatment Plan

Student's Name: ___________________________ Grade: _______________
Student's DOB: ____________________________ Date: ________________

Physician's Name: ______________________________ Telephone Number: ___________________

Known Triggers:
___Colds/Flu
___Exercise
___Allergens: ____Dust Mites, Dust, ____Stuffed Animals, Carpets
____Pollen,Trees,Grass,Weeds ____Mold
____Pets - Animal dander ____Pests - Rodents, Cockroaches
___Odors: ____Cigarette smoke ____Smoke from burning wood, material
____Perfumes,Cleaning products,Scented products
___Weather: ____Sudden temperature changes
____Extreme Weather Temperatures (Hot or Cold)
____Ozone alert days
___Foods:____
___Other:____

Current Asthma and Allergy Medications :(meds/ dosages/frequency)

____
____
____

Treatment instructions:

1. In the event of an asthma flare-up, the student will report to the school nurse for assessment. If the child has previously been designated to self-administer a rescue MDI, they will be allowed to utilize their MDI until medically evaluated by the school nurse. A Parent/Guardian will be contacted.

2. The School Nurse will assess the student and if the student requires treatment for Asthma, **administer Albuterol 0.083% 2.5mg in 3ml unit dose Nebulizer Solution every 15min as needed for up to 3 doses.** The student's disposition (i.e. whether he/she can remain at school or be sent for medical evaluation) will be dependent on this initial treatment outcome.

3. If after 3 nebulizer treatments the student is still symptomatic you may continue to administer **Albuterol 0.083% 2.5mg in 3ml unit dose Nebulizer Solution every 15min** while waiting for transportation to their primary physician or ER depending on the severity of symptoms.

4. If the student (who remained at school after the first course of treatment) develops a flare-up of symptoms later that day, treatment protocol will be re-instituted; the student will not be allowed to remain in school and must be referred to their primary physician or ER depending on the severity of symptoms.

5. If respiratory distress is part of an anaphylactic reaction, administer Epinephrine and Diphenhydramine as per the school's standing orders or individual student orders if available. Call EMS ASAP.

Signature of Physician: _____________________________________ Date:_______________
Physician Stamp:

AUTHORIZATION FOR ADMINISTRATION OF ASTHMA PRESCRIPTION MEDICATION

RECOMMENDATIONS ARE EFFECTIVE FOR THE CURRENT SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY

Student Name: ___________________________ DOB: _________________ Grade: ________________________
Emergency Contacts: (Name and Phone#'s):____
____

I. Parental/Guardian Consent for Administration of Asthma medication

___**I request that my child be ALLOWED to carry and self-administer in school**, his asthma medication listed below pursuant to N.J.S.A. 18A:40-12.3 and 12.4. I give permission for my child to self-administer his/her medication, as prescribed on this form for the current school year. I consider him/her to be responsible and capable of transporting, storing and self-administrating the medication. 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 asthma medication.** I request that my child be assisted in taking the medication described below at school by the School Nurse or other individuals authorized to administer medication to students in school pursuant to N.J.A.C:.6A:16-2.3. I understand the ultimate responsibility for administration of the medication is mine, and I am fully aware that the duties of the school nurse and others may require their presence at another location at the time that the medication is needed. 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 administration or lack of administration 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 administration or lack of administration of this medication.

______________________________ ________________________ ____________
Parent/Guardian Signature Telephone Date

II. Healthcare Provider Order:

Name of medication: ____

Dosage: ___________________________ Route: __________________Frequency:_____________________________

For Student Self Administration:
_____This student has been instructed in and is capable of proper method of self-administration of the medication prescribed above.
_____This student understands the purpose, appropriate method and frequency of use of the medication prescribed above.

____This student is **not** approved to self-medicate

____
Physician's Name Signature Date

Office Stamp:

This form must be individually completed for **all medications**.
Medications are to be brought to school by the parent in the **original container**, labeled appropriately by the pharmacy.
All medications **will be kept** in a locked storage area.

Approved by School Nurse (signature and date): ____

Approved by School MD (signature and date): ____

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