1133 E County Line Rd
Lakewood NJ 08701-2196
Phone: 732-363-3633 **Fax**: 732-363-7337

Dear Calvary Academy Parents;

Our school nurse, Mrs. Tremitiedi, is employed at Calvary Academy for the full school day. There may be times when she is out or unavailable; therefore, I am delegating additional staff members to administer Epipens, or Glucogon injections. The Main Delegates will be Mrs. Stephanie Cruz and Mrs. Laura Dafflisio. The School Nurse will provide training to these delegates.

On the rare occasion the School Nurse is unavailable and your child requires Medication to be administered **other then Epipens, or Glucogon** the Parent or Legal Guardian must come to school to administer the medication if needed.

All medications to be administered to students in school require signed Doctor's orders each school year. If you would like your child to have ANY medications, including over the counter meds such as Advil or Tylenol, during school hours please complete the following form.

If your child requires asthma medication in school please complete the following Asthma Treatment Plan form.

If your child requires an Epipen in school please DO NOT use the following medication form for Epipens. You must use the designated **Epipen FARE form** and consent letter located on our website.

Prescription medications must be provided in the original box with an Rx pharmacy label attached with your child's name. Please check the date for expiration before sending medications to school.

Any additional questions you may have please call or email our School Nurse, Mrs. Tremitiedi @ nurse@calvaryacademy.org.

Sincerely,

Stephanie Cruz
Principal

Catapult Learning™

AUTHORIZATION FOR MEDICATION TO BE GIVEN DURING SCHOOL HOURS

The following section is to be completed by the PARENT:

Child's Name _____ _____ _____
Last First Sex Date of Birth

_____
School Grade

_____
Physician's Name Address Telephone

I request that my child be assisted in taking the medicine(s) described below at school by authorized persons as ordered by my physician (see below).

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

The following is to be completed by the PHYSICIAN:

Diagnosis for which medication is being given: _____

Name of Medicine
Form
Dose
If medication is to be given DAILY, at what time?
If medication is to be given PRN, how often?
How soon may the PRN medication be repeated?
Is this medication required to be administered on class trips?
List significant side effects:
Length of time medication is recommended:

Additional information: _____

_____

_____

Date: _____ Physician's Signature _____

CLHF #29 Rev. 8/11

The Pediatric/Adult Asthma Coalition of New Jersey

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

Asthma Treatment Plan Patient/Parent Instructions

The **PACNJ Asthma Treatment Plan** is designed to help everyone understand the steps necessary for the individual patient to achieve the goal of controlled asthma.

1. Patients/Parents/Guardians: *Before taking this form to your Health Care Provider:*
Complete the top left section with:
- Patient's name
- Patient's date of birth
- Patient's doctor's name & phone number
- Parent/Guardian's name & phone number
- An Emergency Contact person'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 circle 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 you or your child to follow

3. Patients/Parents/Guardians & Health Care Providers together:
Discuss and then complete the following areas:
- Patient's peak flow range in the Healthy, Caution and Emergency sections on the left side of the form
- Patient's asthma triggers on the right side of the form
- For Minors Only 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

This Asthma Treatment Plan is meant to assist, not replace, the clinical decision-making required to meet individual patient needs.
Not all asthma medications are listed and the generic names are not listed.

The Pediatric/Adult Asthma Coalition of New Jersey, sponsored by the American Lung Association of New Jersey, and this publication are supported by a grant from the New Jersey Department of Health and Senior Services (NJDHSS), with funds provided by the U.S. Centers for Disease Control and Prevention (USCDCP) under Cooperative Agreement 5U59EH000206-2. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the NJDHSS or the USCDCP. Although this document has been funded wholly or in part by the United States Environmental Protection Agency under Agreements XA97256707-1, XA98284401-3 and XA97250908-0 to the American Lung Association of 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.

AMERICAN LUNG ASSOCIATION.
of New Jersey

Asthma Treatment Plan

(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"
Original PACNJ approved Plan available at www.pacnj.org

Sponsored by AMERICAN LUNG ASSOCIATION. of New Jersey

NEW JERSEY DEPARTMENT OF HEALTH SENIOR SERVICES

lease Print)

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

HEALTHY

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 medicine(s). All metered dose inhalers (MDI) to be used with spacers.

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

Remember to rinse your mouth after taking inhaled medicine.

If exercise triggers your asthma, take this medicine_____ ____minutes before exercise.

Triggers

Check all items that trigger patient's asthma:

- ☐ Chalk dust
- ☐ Cigarette Smoke & second hand smoke
- ☐ Colds/Flu
- ☐ Dust mites, dust, stuffed animals, carpet
- ☐ Exercise
- ☐ Mold
- ☐ Ozone alert days
- ☐ Pests - rodents & cockroaches
- ☐ Pets - animal dander
- ☐ Plants, flowers, cut grass, pollen
- ☐ Strong odors, perfumes, cleaning products, scented products
- ☐ Sudden temperature change
- ☐ Wood Smoke
- ☐ Foods:

_____
_____
_____

- ☐ Other:

_____
_____
_____
_____
_____

CAUTION

You have *any* of these:
- Exposure to known trigger
- Cough
- Mild wheeze
- Tight chest
- Coughing at night
- Other:_____

And/or Peak flow from _____ to _____

Continue daily medicine(s) and add fast-acting medicine(s).

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Accuneb® ☐ 0.63, ☐ 1.25 mg	.1 unit nebulized every 4 hours as needed
☐ Albuterol ☐ 1.25, ☐ 2.5 mg	.1 unit nebulized every 4 hours as needed
☐ Albuterol ☐ Pro-Air ☐ Proventil®	.2 puffs MDI every 4 hours as needed
☐ Ventolin® ☐ Maxair ☐ Xopenex®	.2 puffs MDI every 4 hours as needed
☐ Xopenex® ☐ 0.31, ☐ 0.63, ☐ 1.25 mg	.1 unit nebulized every 4 hours as needed
☐ Increase the dose of, or add:	

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

EMERGENCY

Your asthma is getting worse fast:
- Fast-acting medicine did not help within 15-20 minutes
- Breathing is hard and fast
- Nose opens wide
- Ribs show
- Trouble walking and talking
- Lips blue • Fingernails blue

And/or Peak flow below _____

Take these medicines NOW and call 911.

Asthma can be a life-threatening illness. Do not wait!

☐ Accuneb® ☐ 0.63, ☐ 1.25 mg	.1 unit nebulized every 20 minutes
☐ Albuterol ☐ 1.25, ☐ 2.5 mg	.1 unit nebulized every 20 minutes
☐ Albuterol ☐ Pro-Air ☐ Proventil®	.2 puffs MDI every 20 minutes
☐ Ventolin® ☐ Maxair ☐ Xopenex®	.2 puffs MDI every 20 minutes
☐ Xopenex® ☐ 0.31, ☐ 0.63, ☐ 1.25 mg	.1 unit nebulized every 20 minutes
☐ Other	

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

The Pediatric/Adult Asthma Coalition of New Jersey, sponsored by the American Lung Association of New Jersey and this publication are supported by a grant from the New Jersey Department of Health and Senior Services (NJDHSS), with funds provided by the U.S. Centers for Disease Control and Prevention (USCDCP) Cooperative Agreement SU59EH000206-2. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of NJDSS or the USCDCP.

Although this document has been funded wholly or in part by the United States Environmental Protection Agency under Agreements X0982244-01-4 and X0972507-1 to the American Lung Association of 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.

EFFECTIVE MARCH 2008

Permission to reproduce blank form Approved by the New Jersey Thoracic Society

FOR MINORS ONLY:

☐ This student is capable and has been instructed in the proper method of self-administering of the 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

Make a copy for patient and for physician file. For children under 18, send original to school nurse or child care provider.