

Individualized Asthma Treatment Plan

May 20, 2015

Dear Parent or Guardian,

New Jersey law requires each Asthmatic Student in our school district to have an Individualized Emergency Asthma Treatment Care Plan completed by your physician. This treatment plan will be utilized in the event your child has 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 health care plan, pursuant to N.J.A.C.6A:16-2.1(a), for meeting medical needs of the student while attending school or a school sponsored event".

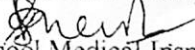
Your patient has been identified to be in need of an Individual Asthma Emergency Treatment Plan. In an effort to simplify the paperwork, I have developed an asthma treatment plan for your review. This is an emergency care plan that will be utilized in the event your patient has an asthma flare-up while 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: *AUTHORIZATION FOR ADMINISTRATION OF ASTHMA PRESCRIPTION MEDICATION* Form.

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

Sincerely,

Sathesh Porur Evalappan, M.D


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-administering 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): _____

V042012