Columbus School

Robert Cannizzaro
Principal

370 Westervelt Place, Lodi, New Jersey 07644
robert.cannizzaro@lodi.k12.nj.us

Tel: (973) 478-0514 . Fax: (973) 478-7753

Asthma Packet

Date: _____

Dear Parent/Guardian of Student: .....

You have indicated that the above-named student has asthma. If your child uses an inhaler, please have the enclosed forms filled out by your healthcare provider and yourself. In the event that an inhaler is not used in school, please complete the bottom portion of this letter and return to my office.

It is important that the appropriate form be returned to me as soon as possible.

I thank you for your attention to this matter. Please contact the school nurse at your child's school if you need assistance or have any questions.

Sincerely,

Ms. Lisa Cangialosi, RN, BSN

School Nurse
973-478-3503

Asthma without inhaler

My son/daughter _____ ,does have asthma, but does not need to use and/or carry an inhaler in school. He/she has no limitations on his/her physical activity.

Date: .....

_____

Parent/Guardian Signature

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Medical Authorization Form

School Year: _____ School: _____

Physician's Order

Student: ..... DOB: .....

Medication: ..... Dosage: .....

Time: _____ Frequency: _____

(If a PRN Medication Please indicate the frequency with which it can be repeated)

Reason for Medication: .....

Possible Side Effects: .....

Date medication is to be discontinued: .....

Physician's Comments (if needed):

_____

_____

_____

Date: .....

Please Stamp Below

_____

Physician's Signature

_____

Address

_____

Telephone

_____

I request that my son/daughter _____, be administered the medication prescribed above by the school nurse.

Date: .....

_____

Parent/Guardian Signature

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INDEMNIFICATION/HOLD HARMLESS AGREEMENT FOR SELF-ADMINISTRATION OF MEDICATION

The parent(s)/guardian(s) agree(s) to indemnify, defend and hold the school district harmless from any and all claims, actions, expenses, damages and liabilities, including attorney's fees, arising out of, connected with or resulting from the self-administration of medication by the pupil. The parent(s)/guardian(s) agree(s) to extend this indemnification/hold harmless agreement to the board of education, board of education employees and agents. The parent(s)/guardian(s) agree(s) the school district, board of education, board of education employees and its agents shall incur no liability as a result of any injury arising out of or connected with the self-administration of medication by the pupil.

This agreement shall take effect on the date listed below and shall stay in effect for as long as the pupil is provided permission to self-administer medication. This agreement must be signed and in full effect prior to the granting of permission to self-administer medication.

Student's Name

Building Principle

Parent/Guardian's Name

Parent/Guardian's Name

Parent/Guardian's Signature

Parent/Guardian's Signature

Date of Agreement

ADMINISTRATION OF MEDICATION Policy No. 5330

The Board of Education disclaims any and all responsibility for the diagnosis and treatment of the illness of any pupil. However, in order for many pupils with chronic health conditions and disabilities to remain in school, medication may have to be administered during school hours. Parents and legal guardians are encouraged to administer medications to children at home whenever possible as medication should be administered in school only when necessary for the health and safety of pupils. The Board will pe1TI1it the administration of medication in school in accordance with applicable law.

Medication will only be administered to pupils in school by the school physician, a certified or noncertified school nurse; a substitute school nurse employed by the. district, the pupil's parent(s) or legal guardian(s), a pupil who is approved to self-administer in accordance with N.J.S.A_ 18A:40-12.3 and 12.4, and school employees who have been trained and designated by the certified school nurse to administer epinephrine in an emergency pursuant to N.J.S.A. 18A:40-12.5 and 12.6.

Self-administration of medication by a pupil for asthma or other potentially life-threatening illness or a life-threatening allergic reaction is permitted in accordance with the provisions of N.J.S.A. 18A:40-12.3.

Medication no longer required must be promptly removed by the parent(s) or legal guardian(s).

The school nurse shall have the primary responsibility for the administration of epinephrine. However, the certified school nurse may designate, in consultation with the Board or the Superintendent, additional employees of the district who volunteer to be trained in the administration of epinephrine via a pre-filled auto-injector mechanism using standardized training protocols established by the Department of Education in consultation with the Department of Health and Senior Services when the school nurse is not physically present at the scene.

The school nurse or designee shall be promptly available on site at the school and at school-sponsored functions in the event of an allergic reaction. In addition, the parent(s) or legal guardian(s) must be informed that the school district; its employees and agents shall have no liability as a result of any injury arising from the administration of epinephrine to the pupil.

The parent(s) or legal guardian(s) of the pupil must sign a statement acknowledging their understanding the district shall have no liability as a result of any injury arising from the administration of the epinephrine via a pre-filled auto-injector mechanism to the pupil and the parent(s) or legal guardian(s) shall indemnify and hold harmless the district and *its:* employees or agents against any claims arising out of the administration of the epinephrine via a pre-filled auto-injector mechanism to the pupil.

The permission for the emergency administration of epinephrine via a pre-filled auto-injector mechanism containing epinephrine to pupils for anaphylaxis is effective for the school year it is granted and must be renewed for each subsequent school year.

Each school in the district shall have and maintain for the use of pupils at least one nebulizer in the office of the school nurse or a similar accessible location. Each certified school nurse or other persons authorized to administer asthma medication will receive training in airway management and in the use of nebulizers and inhalers consistent with State Department of Education regulations. Every pupil that is authorized to use self-administered asthma medication pursuant to N.J.S.A. 18A:40-l2.3 or a nebulizer must have an asthma treatment plan prepared by the pupil's physician which shall identify, at a minimum, asthma triggers, the treatment plan and other such elements as required by the State Board of Education.

All pupil medications shall be appropriately maintained and secured by the school nurse, except those medications to be self-administered by pupils. In those instances, the medication may be retained by the pupil with the prior knowledge of the school nurse. The school nurse may provide the Principal and other teaching staff members concerned with the pupil's educational progress with such information about the medication and its administration as may be in the pupil's best educational interests. The school nurse may report to the school physician any pupil who appears to be affected adversely by the administration of medication and may recommend to the Principal the pupil's exclusion pursuant to law.

The school nurse shall document each instance of the administration of medication to a pupil. Pupils self-administering medication shall report each incident to a teacher, coach or other individual designated by the school nurse who is supervising the pupil during the school activity when the pupil self-administers. These designated individuals shall report such incidents to the school nurse within twenty-four hours of the self-administration of medication. The school nurse shall preserve records and documentation regarding the self-administration of medication in the pupil's health file.

N.J.S.A. 18A:6-l.1; 18A:40-3.l; 18A:40-6; 18A:40-7; l&A:40-12.3;
18A:40-12.4; 18A:40-12.5; 18A:40-12.6; 18A:40-12.7;
18A:40-12.8
N.J.S.A. 45:11-23 .
NJ.AC. 6A:16-2.3(b)

Date Adopted: 5/6/80
Date(s) Revised: 4/14/94, 9/27/95, 5/26/99, 6/25/03, 10/26/05, 1/23/08

ALCOHOLIC BEVERAGES ON SCHOOL PREMISES Policy No. 7435

The knowing possession, without legal authority, or knowing consumption of any alcoholic beverage by any person on school premises is a disorderly person's offense.

The Board of Education prohibits the possession and consumption of an alcoholic beverage, without the express written permission of the Superintendent, by any person in any school building and on school property or at any school sponsored-activity.

The Board will report to law enforcement officials and prosecute as appropriate any person who violates law and this policy, except that any pupil who possesses or uses or is under the influence of alcohol on school premises or at any school sponsored activity will be treated in accordance with law and Policy Nos. 3218, 4218, and 5530.

School district employees who violate this policy or are present on school premises or at any school sponsored activity while under the influence of alcohol will be subject to discipline, which may include dismissal or certification of tenure charges, as appropriate.

N.J.S.A. 2C:33-15 et seq.
N.J.S.A. 18A:40A-12
N.J.S.A. 24:21-2 et seq.

Date Adopted: 7-22-08

ASSAULTS ON DISTRICT BOARD OF EDUCATION MEMBERS OR EMPLOYEES Policy No. 5612

Any student who commits an assault, as defined under N.J.S.A. 2C:12-l(a)l, not involving the use of a weapon or firearm, upon a teacher, administrator, other school district employee, or Board member acting in the performance of his or her duties and in a situation where bis or her authority to act is apparent, or as a result of the victim's relationship to the school district, shall be immediately removed from school pursuant to N.J.S.A. lSA:37-2.1 and N.J.A.C. 6A:16-5.7.

A student, other than a student with a disability, who commits an assault as defined in N.J.S.A. 2C:12-l(a)l shall be immediately removed from school consistent with due process procedures, pending a hearing pursuant to NJ.AC. 6A:16-7.2 through 7.5. Nothing in N.J.S.A. 18A:37-2.1 or N.J.A.C. 6A:16-5.7 shall be construed as prohibiting the expulsion of a general education student. A student with a disability who commits an assault a defined in this Policy, shall be removed in accordance with NJ.AC. 6A:14 and due process proceedings in accordance with N.J.A.C. 14-2.7 and 2.8.

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 Phone	Parent/Guardian (if applicable) Phone	Emergency Contact 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.

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 #U66EH000491-5. 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 XA98226601-2 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.

REVISED AUGUST 2014

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

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 _____

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