MONTGOMERY TOWNSHIP SCHOOLS
Skillman, New Jersey

SCHOOL HEALTH SERVICES

Student's Name: _____ **Date of Birth:** _____
(Please Print)

Gender: Male / Female (circle one)

My child previously attended a Montgomery Twp. School? Yes / No (circle one)

If yes, circle last school attended OHES VES LMS UMS MHS

HEALTH HISTORY

Has Your Child Had:	NO	YES	YEAR
Chicken Pox			
Heart Problems			
Kidney Problems			
Bladder Problems			
Asthma			
Bronchitis			
Strep Infection			
Mononucleosis			
Diabetes			
Convulsions			
Hepatitis			
Rheumatic Fever			
Pneumonia			

Does your Child Have:	YES/TYPE	NO
Congenital Defects		
Drug Sensitivities		
Neuromuscular Disease		
Speech Problems		
Vision Problems		
Eyeglasses		
Hearing Problems		

Has your child had:	If yes, description and date.
Any severe injury?	
Any operations?	

Initial the statement that applies to your child:

___ My child does **not** have a life-threatening allergy requiring the use of epinephrine.

___ My child has a life-threatening allergy requiring the use of epinephrine.
Please complete the Life-Threatening Allergy Questionnaire on the following page.

Parent/Guardian Signature: _____ Date: _____

PLEASE COMPLETE THE NEXT FORM ONLY IF YOUR CHILD HAS ANY LIFE-THREATENING ALLERGIES.

Montgomery Township School District

EMERGENCY ALLERGY ACTION PLAN

School Year: _____

Photo Here

Student Name: _____ Date of Birth: _____

Allergic to (list allergens that may cause anaphylaxis):

_____

Teacher: _____ Home Room: _____ Grade: _____

Healthcare Provider- Complete, Initial Capacity Statements, Sign, Date, & Stamp:

Current Weight: _____ Epinephrine Auto-Injector Dose: ☐ 0.15 mg (Jr) ☐ 0.3 mg (Adult)

Antihistamine (drug/dose): _____

History of Asthma or Reactive Airway: ☐ No ☐ Yes Bronchodilator (drug/dose): _____

Capacity for self-administration of epinephrine (Healthcare provider- initial box next to applicable statement(s):
You may select a combination of options. If for any reason the student cannot self-administer, the school nurse, or delegate will give epinephrine. Delegates are not authorized by NJDOE to administer antihistamines or bronchodilators.

☐ Student will carry and self-administer epinephrine.

☐ Student will carry, but cannot self-administer.

☐ Student's epinephrine is kept in the health office for administration by the school nurse or delegate

Office Stamp

Healthcare Provider Signature: _____ Date: _____

Parent/Guardian- Review Statements, Sign, Date, & Complete:

**Each school year, you must provide the school nurse with all unexpired emergency medication(s) ordered by your child's healthcare provider along with an updated Emergency Allergy Action Plan. Your child will not be permitted to participate in athletics, day or overnight off-campus trips, and school sponsored events without their medication(s), and an Emergency Allergy Action Plan on file in the health office.*

I understand that in the event of an anaphylactic emergency, epinephrine will be administered to my child by a school nurse or delegate as indicated in this Emergency Allergy Action Plan. My signature indicates acknowledgement that the Montgomery Township School District, and its employees or agents, shall have no liability as a result of any injury arising from the administration of epinephrine to my child. I shall indemnify and hold harmless the district and its employees or agents against any claims arising out of the administration of epinephrine via a pre-filled auto injector mechanism.

Parent/Guardian Signature: _____ **Date:** _____

Parent/Guardian/Emergency Contact Information: Please **print** legibly all contact names and phone numbers in order of priority.

1. _____
Name (print clearly) Preferred Phone Alternate Phone

2. _____
Name (print clearly) Preferred Phone Alternate Phone

3. _____
Name (print clearly) Preferred Phone Alternate Phone

EPINEPHRINE ADMINISTRATION INSTRUCTIONS ON BACK OF FORM

IDENTIFY SYMPTOMS → INJECT EPINEPHRINE → CALL 911

SEVERE SYMPTOMS

One or **more** of the following:

LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, Blue, Faint, weak pulse, dizzy
THROAT: Tight, hoarse, trouble swallowing or breathing
MOUTH: Obstructive swelling (tongue and /or lips)
SKIN: Many hives over body
GUT: Vomiting, diarrhea, crampy pain
OTHER: Anxiety, confusion, feeling of unease

Or a **Combination** of symptoms from different body areas

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. CALL 911 – Request Ambulance with epinephrine
3. Continually monitor student's condition
4. Administer antihistamines & inhaler/bronchodilator··· as ordered by HCP (only RNs may administer)*

*Delegates are not authorized to administer antihistamines or bronchodilators per statute- N.J.S.A. 18A:40-12.6.···Antihistamines & Inhaler-bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis)- **USE EPINEPHRINE**

If **MILD SYMPTOMS** From **MORE THAN ONE** Body System, **GIVE EPINEPHRINE**

For MILD SYMPTOMS From a SINGLE BODY SYSTEM

Nose: Itchy or runny nose, sneezing
Mouth: Itchy mouth / throat
Skin: A few hives, mild itch
Gut: Mild nausea / stomach ache

→

Give antihistamines as ordered by healthcare provider.

Stay with person; alert emergency contacts.

Watch closely for changes.

If symptoms worsen, give epinephrine & call 911

TO INJECT EPINEPHRINE:

1. REMOVE AUTO-INJECTOR FROM PROTECTIVE CASE
2. REMOVE ALL PROTECTIVE CAPS
3. GRASP AUTO-INJECTOR, SWING AND PUSH FIRMLY AGAINST MIDDLE OF OUTER THIGH HOLD FIRMLY IN PLACE FOR 3 SECONDS (COUNT SLOWLY)
4. REMOVE AND MASSAGE THE INJECTION SITE FOR 10 SECONDS.

Revised: 2020-12-10

PLEASE HAVE YOUR CHILD'S DOCTOR COMPLETE THE NEXT FORM IF YOUR CHILD HAS ASTHMA

Asthma Treatment Plan – Student

(This asthma action plan meets NJ Law N.J.S.A. 18A:40-12.8) **(Physician's Orders)**

PACNJ Pediatric/Adult Asthma Coalition

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 5U58EH000401-5. 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 XA96296601-2 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 MAY 2017

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 _____

The Pediatric/Adult Asthma Coalition of New Jersey
"Your Pathway to Asthma Control"
PACNJ approved Plan available at www.pacnj.org
Pediatric/Adult Asthma Coalition

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