**Attachment A**

**WASHINGTON TOWNSHIP PUBLIC SCHOOLS**

# REQUEST FOR PUPIL MEDICATION TO BE TAKEN AT SCHOOL

The administration of medication to or by any pupil will be permitted only when failure to take such medication would jeopardize the health of the pupil or the pupil would not be able to attend or benefit from his/her educational program. Medication includes all prescriptions and patent medications (over the counter). Washington Township Public Schools requires both physician and parent permission to administer all medication, including patent (over the counter) medication.

**Note to Parent/Guardian:** All medication(s) whether patent or prescribed shall be provided to the school nurse by the parent/guardian in the original container. In the case of prescription medication, the original container must have affixed the current prescription labeling as applied by the pharmacy.

Authorizations are effective for one school year only and must be renewed annually. All forms must be received and be on file in the school's Health Office before any medication can be administered.

**SECTION A: Parent Request and Consent (To be completed by *Parent/Legal Guardian*)**

**PLEASE PRINT:**

Pupil's Name: _____ School: _____

Parent's/Guardian's Name: _____

Address: _____

Home Phone #: _____ Parent's/Guardian's Work Phone: _____

---

**PARENT'S CONSENT AND SIGNATURE**

I, _____ (Name of Parent/Legal Guardian), request that my child, _____, be assisted in taking the medication(s) described above at school, as authorized by me and my physician.

_____ _____

Parent/Guardian Signature Date

**See back of page for information to be completed by physician**

**SECTION B: Physician's Certification (To be completed by the *Physician*)**

Physician: _____

Diagnosis for which medication is given: _____

Name of medicine: _____

Form (oral, injection): _____

Dose: _____

If given daily, at what time? _____

If given when needed, describe indications. _____

How soon can it be repeated? _____

Are there significant side effects? _____

Length of time this treatment will continue? _____

Other significant information: _____

I certify that the above statements are true and that the pupil is physically fit to attend school and is free from contagious disease. He (she) would not be able to attend school if the medication is not administered during school hours.

Physician Signature _____ Date _____

Affix physician's official stamp here:

**SECTION C: Nurse's Review (To be completed by the *School Nurse)***

Pupil's Name: _____

Check one:

_____ The request for administration of the above-referenced medication by the school nurse is approved.

_____ The request for administration of the above-referenced medication by the school nurse is denied.

Reason for Denial: _____

_____

_____

_____

The parent/legal guardian has the right to appeal the denial to the Principal.

_____ _____

Signature of Nurse Date

**Section D: Controlled Substance Record (To be completed for all controlled medications)**

| Date of Receipt | Quantity Received | Parent's Signature | Nurse's Signature |
|---|---|---|---|
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**WASHINGTON TOWNSHIP PUBLIC SCHOOLS**

## Authorization Form for Pupil Self-Administration of Medication(s) and Other Potentially Life-Threatening Illness(es) and/or Life-Threatening Allergic Reactions(s)

Permission for self-administration of medication of a pupil with asthma, other potentially life-threatening illness, or a life-threatening allergic reaction may be granted under the following conditions:

1. Signed parental authorization for the self-administration of medication.
2. The parent(s) or legal guardian(s) of the pupil must also provide the Board with a signed written certification from the physician of the pupil that the pupil has asthma or another potentially life threatening illness or is subject to a life-threatening allergic reaction and is capable of, and has been instructed in, the proper method of self-administration of medication. (Attachment C.1)
3. A statement the medication must be administered during the school day or the pupil would not be able to attend school.
4. The parent(s) or legal guardian(s) of the pupil have signed a statement acknowledging that the school district shall incur no liability as a result of any injury arising from the self-administration of medication by the pupil and that the parent(s) or legal guardian(s) shall indemnify and hold harmless the school district, the Board, and its employees or agents against any claims arising out of the self-administration of medication by the pupil.
5. The parent's and/or legal guardian's written authorization and the home physician's written certification shall be reviewed by the school nurse and the school physician. The school nurse and the school physician must agree the pupil is capable of self-administration of the medication. If it is determined the pupil may self-administer medication in accordance with the request, the request will be signed by the principal and a copy given to the school nurse and the pupil's parent(s) or legal guardian(s). If it is determined that the request for self-administration will be denied, the school nurse will notify the Principal and then inform the parent(s) or legal guardian(s) of the reason for a denied request; a denied request may be appealed to the Principal.
6. Permission to self-administer one medication shall not be construed as permission to self-administer other medications; and
7. Permission shall be effective for the school year for which it is granted and shall be renewed for each subsequent school year upon fulfillment of the requirements in 1. through 4. above.
8. The student's ability to self-administer a particular medication shall be documented in his/her Individualized Healthcare Plan. The Individualized Healthcare Plan shall also indicate how the medication will be pre-measured, labeled, and carried to ensure that the student carries only the quantity necessary for a prescribed time.

## Authorization Form for Pupil Self-Administration of Medications for Asthma and Other Potentially Life-threatening Illnesses and/or Life-Threatening Allergic Reactions

Authorizations are effective for one school year only and must be renewed annually. All forms must be received and be on file in the school's Health Office before any medication can be administered. Permission shall be effective for the school year for which it is granted and shall be renewed for each subsequent school year upon fulfillment of the requirements in 1. through 5. listed on Attachment C.

**SECTION A: Parent's/Legal Guardian's Consent and Acknowledgements**
**(To be completed by the student's *Parent/Legal Guardian*)**

I (we), _____, (name of parent/legal guardian) authorize my(our) child, _____ _____, (child's name) to self-administer prescribed medication to treat his/her medical condition which is deemed potentially life threatening for the _____ to _____ school year. The specific medication(s) are (please list specific medication(s) _____ _____, as indicated on the attached certification from my child's physician, Dr._____ _____ (name of physician). It is also understood that permission for our child to self-administer this (above listed) medication shall not be construed as permission to self-administer other medications. I/we understand that permission shall be effective for the school year for which it is granted and shall be renewed for each subsequent school year upon fulfillment of necessary requirements.

I (we) understand that the Washington Township Board of Education and its employees and agents shall incur no liability as a result of any injury arising from our child's self-administration of medication and that we (the parents/legal guardians) shall indemnify and hold harmless the school district, the Board, and its employees or agents from any and all claims arising through the self-administration of this medication by our child.

**Signature of Parent(s)/Legal Guardian**

_____ _____
Mother/Legal Guardian Date

_____ _____
Father/Legal Guardian Date

Name, Address, and Phone Number of Child's Physician: _____

_____

_____
Phone Street Address City, State, Zip

**WASHINGTON TOWNSHIP PUBLIC SCHOOLS** **Attachment C.1-B (Cont.)**

## Authorization Form for Pupil Self-Administration of Medications for Asthma and Other Potentially Life-threatening Illnesses and/or Life-Threatening Allergic Reactions

**SECTION B: Physician's Certification (To be completed by *pupil's* physician)**

Pupil's Name: _____ Age: _____ Grade: _____ School: _____

Name of Medication: _____

Dosage: _____ Frequency: _____ Oral: _____ Parenteral: _____

Possible Side Effects:

_____

Date When Medication Will Be Discontinued: _____

Specific Nature of Pupil's Illness/Condition:

_____

It is my understanding that the School Nurses of Washington Township Public Schools charged with the administration of medication may rely upon my directions as contained in this document. Pupils with asthma or other potentially life threatening illnesses deemed sufficiently responsible by their physician and parent shall be permitted to have in their possession prescribed medication for the treatment and prevention of life-threatening illnesses or condition during school hours, athletic events and practices and field trips. I hereby deem the above named pupil to be sufficiently capable having been instructed in the proper method of self-administration of medication pursuant to Chapter 308 of the laws of 1993, to carry his/her prescribed medication of the medication listed above. I further certify that I am the physician who prescribed the medication and that the pupil named above is under my supervision as a patient for diagnosis and treatment. Any alteration to the above will occur only with written directions from the attending physician.

I certify that the above statements are true and that the pupil is physically fit to attend school and is free from contagious disease. He (she) would not be able to attend school if the medication is not administered during school hours.

_____ _____

Physician's Name (Please Print/Type) Physician's Signature

Address: _____

Date: _____ Telephone: _____

Affix physician's official stamp here:

**Washington Township Public Schools** **Attachment C.1-C**

## Authorization Form for Pupil Self-Administration of Medications for Asthma and Other Potentially Life-threatening Illnesses and/or Life-Threatening Allergic Reactions

**SECTION C: SCHOOL OFFICIAL'S REVIEW AND CONCURRENCE**
**(This section is to be completed by the *School Nurse and the School Physician.*)**

**SCHOOL NURSE AND SCHOOL PHYSICIAN**

I have reviewed the parent's/legal guardian's written authorization and the pupil's physician's written certification and agree that the above-referenced pupil is capable of self-administration of the medication prescribed by the pupil's physician.

| | |
|---|---|
| School Nurse's Name (Print) | School Physician's Name (Print) |
| School Nurse's Signature | School Physician's Signature |
| Date | Date |

Affix school physician's official stamp here:

BUILDING PRINCIPAL

I have reviewed this request for self-administration with the school nurse and school physician. The school nurse and school physician agree that this pupil, _____,
is capable of self-administration of the medication prescribed by the pupil's physician. It is therefore determined that the pupil may self-administer this medication in accordance with the parent's/legal guardian's request.

| | |
|---|---|
| Principal/Administrative Designee Signature | Date |

**Attachment D**

## Washington Township Public Schools

# ASTHMA QUESTIONNAIRE

*If your child has Asthma, please complete the questionnaire below and return to the Health Office. Thank You!*

Effectively managing asthma requires a partnership among the student, parent(s) or guardian(s), the physician, and other adults who work with your child. To protect students and to guide staff, we ask that you fill in the information below. Guidelines are in place to contact you in the event of an emergency. Please follow the established procedure for administration of medication while at school. Please call the School Nurse if you have any concerns or questions.

Name: _____ Grade: _____ Teacher: _____

Identify the things which start an asthma episode (check all that apply to your child)

☐ Exercise
☐ Respiratory Infections
☐ Change in Temperature
☐ Animals (Specify below)
_____
☐ Food (Specify below)
_____
☐ Strong Odors or Fumes

☐ Chalk Dust
☐ Carpets in the Room
☐ Pollens
☐ Dust Mites
☐ Mold
☐ Other
_____

☐ Spring
☐ Fall/Autumn
☐ Year Round

**1.** What are the signs of an asthma attack in your child? _____

_____

**2.** If your child uses a Peak Flow Meter, please indicate his/her personal best Peak Flow number. _____

**3.** List all medication(s) your child takes.

_____

_____

**4.** Will your child need to take medication for asthma during the school day?

_____ Yes _____ No

If you answered "yes", please be sure to see the nurse to obtain the "*Request for Medication to be Administered at School*" form that must be filled out by your doctor and you.

**5.** Control of School Environment
List any environmental control measures, pre-medications, and/or dietary restrictions that the student needs to prevent an asthma episode:

_____

_____

**6.** Has your child ever been hospitalized for asthma? If yes, when? _____

**7.** Has your child ever been evaluated by an asthma/allergy specialist? If yes, when? _____

Parent/Guardian Name (Please Print):_____

Parent/Guardian Signature: _____ Date: _____

2.

The Pediatric/Adult Asthma Coalition of New Jersey

*"Your Pathway to Asthma Control"*

# 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 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 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.

# Asthma Treatment Plan The Pediatric/Adult Asthma Coalition of New Jersey

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

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

3.

## 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). Some metered dose inhalers may be more effective with a "spacer" – use if directed.

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
- ☐ Alvesco® ☐ 80, ☐ 160 _____ ☐ 1, ☐ 2 puffs MDI twice a day
- ☐ Asmanex® Twisthaler® ☐ 110, ☐ 220_____☐ 1, ☐ 2 inhalations ☐once or ☐ twice a day
- ☐ Flovent® ☐44, ☐110, ☐220_____2 puffs MDI 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® ☐.25, ☐0.5, ☐1.0_____1 unit nebulized ☐once or ☐twice a day
- ☐ Qvar® ☐40, ☐80_____☐1, ☐2 puffs MDI twice a day
- ☐ Singulair ☐4, ☐5, ☐10 mg_____1 tablet daily
- ☐ Symbicort® ☐80, ☐160_____☐1, ☐2 puffs MDI twice a day

**If exercise triggers your asthma, take this medicine _____ _____ minutes before exercise**

## 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® ☐ 63, ☐ 1.25 mg _____ 1 init nebulized every 4 hours as needed
- ☐ Albuterol ☐ 1.25, ☐ 2.5 mg _____ 1 init nebulized every 4 hours as needed
- ☐ Albuterol ☐Pro-Air ☐Proventi_____ 2 puffs MDI every 4 hours as needed
- ☐ Ventolin® ☐ Maxair ☐ Xopenex®_____2 puffs MDI every 4 hours as needed
- ☐ Ventolin® ☐0.31, ☐0.63, ☐1.25 mg___1 unit nebulized every 4 hours as needed
- ☐Increase the dose of, or add:
- ☐ Other: _____

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

ion New Jersey Department of Health and Senior Services

## 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 ☐ Proventi®_____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_____

**Physician/APN/PA Signature** _____ Date:_____

Parent/Guardian Signature _____ Date:_____

Physician Stamp

**FOR MINORS ONLY:**
☐ **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.**
Make a copy for patient and for physician file. For Children under 18, send original to school nurse or child care provider.

## Triggers

Check all items that trigger patient's asthma:

- ☐ Chalk dust
- ☐ Cigarette Smoke and 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
- ☐ Sudden Temperature change
- ☐ Wood Smoke
- ☐ Foods:

_____
_____
_____

☐ Other

_____
_____
_____
_____
_____

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