**Green Brook Family Medicine**

Ronald M Frank, MD FAAFP
Sean M Cook, MD, FAAFP
Clair Carragino, APN-C
Allyssa R. Finer, APN-C

328 Greenbrook Road
Green Brook, New Jersey 08812

Phone 732.356.0266
Fax 732.356.5022

# 2021 Asthma Packet Instructions

In the past we utilized 3 forms for the Asthma packet. We are discontinuing future use of those forms. The NY Asthma Action Plan (with minor modification) does meet the criteria for use in NJ. It has the demographic information, triggers, action plan and necessary signatures for nurse treatment and potential self-carry. I would distribute this form when needed but understand that their primary doctor may have their own template that they use. If so, it needs to have the following information:

--Demographics
--Triggers
--Treatment plan
--Provider's signature for treatment at school
--Parental signature consenting for treatment at school
--Optional: Provider's signature for self-carry and if ordered, the parent's signature as well.

The student's disposition after treatment will need to be coordinated with parent and possibly the student's physician. For example, can they stay at school. Or do they need to go home, doctor or the ER. This may not be clearly spelled out on the form.

Any student with asthma who does not have an asthma treatment plan would be treated under our standing orders.

# Asthma Action Plan

Date Completed

| Name | Date of Birth | Grade/Teacher |
|---|---|---|
| Health Care Provider | Health Care Provider's Office Phone | Medical Record Number |
| Parent/Guardian | Phone | Alternate Phone |
| Parent/Guardian/Alternate Emergency Contact | Phone | Alternate Phone |

**DIAGNOSIS OF ASTHMA SEVERITY**

☐ Intermittent ☐ Persistent [ ○ Mild ○ Moderate ○ Severe ]

**ASTHMA TRIGGERS** (Things That Make Asthma Worse)

☐ Smoke ☐ Colds ☐ Exercise ☐ Animals ☐ Dust ☐ Food
☐ Weather ☐ Odors ☐ Pollen ☐ Other _____

## GREEN ZONE: GO!

Take These **DAILY CONTROLLER MEDICINES (PREVENTION)** Medicines **EVERY DAY**

**You have ALL of these:**
- Breathing is easy
- No cough or wheeze
- Can work and play
- Can sleep all night

☐ No daily controller medicines required

☐ Daily controller medicine(s): _____

☐ _____
**Take _____ puff(s) or _____ tablet(s) _____ daily.**

☐ For asthma with exercise, ADD: _____,
**_____ puffs with spacer _____ minutes before exercise**

**ALWAYS RINSE YOUR MOUTH AFTER USING YOUR DAILY INHALED MEDICINE.**

## YELLOW ZONE: CAUTION!

Continue **DAILY CONTROLLER MEDICINES** and **ADD QUICK-RELIEF** Medicines

**You have ANY of these:**
- Cough or mild wheeze
- Tight chest
- Shortness of breath
- Problems sleeping, working, or playing

Take daily controller medicine if ordered and add this quick-relief medicine when you have breathing problems:

☐ _____ inhaler _____ mcg
**Take _____ puffs every _____ hours, *if needed.* Always use a spacer, some children may need a mask.**

☐ _____ nebulizer _____ mg /_____ ml
**Take a _____ nebulizer treatment every _____ hours, *if needed.***

☐ Other _____

If quick-relief medicine does not HELP within _____ minutes, take it again and CALL your Health Care Provider

If using quick-relief medicine more than _____ times in _____ hours, CALL your Health Care Provider

**IF IN THE YELLOW ZONE MORE THAN 24 HOURS, CALL HEALTH CARE PROVIDER.**

## RED ZONE: EMERGENCY!

Continue **DAILY CONTROLLER MEDICINES** and **QUICK-RELIEF** Medicines and **GET HELP!**

**You have ANY of these:**
- Very short of breath
- Medicine is not helping
- Breathing is fast and hard
- Nose wide open, ribs showing, can't talk well
- Lips or fingernails are grey or bluish

☐ _____ inhaler _____ mcg
**Take _____ puffs every _____ hours, *if needed.* Always use a spacer, some children may need a mask.**

☐ _____ nebulizer _____ mg /_____ ml
**Take a _____ nebulizer treatment every _____ hours, *if needed.***

☐ Other _____

**CALL HEALTH CARE PROVIDER AGAIN WHILE GIVING QUICK-RELIEF MEDICINE. If health care provider cannot be contacted, CALL 911 FOR AN AMBULANCE OR GO DIRECTLY TO THE EMERGENCY DEPARTMENT!**

## REQUIRED PERMISSIONS FOR ALL MEDICATION USE AT SCHOOL

**Health Care Provider Permission:** I request this plan to be followed as written. This plan is valid for the school year _____ – _____.

Signature _____ Date _____

**Parent/Guardian Permission:** I give consent for the school nurse to give the medications listed on this plan [illegible]

Signature _____ Date _____

## OPTIONAL PERMISSIONS FOR INDEPENDENT MEDICATION CARRY AND USE AT SCHOOL

**Health Care Provider Independent Carry and Use Permission:** I attest that this student has demonstrated to me that they can self-administer this rescue medication effectively and may carry and use this medication independently at school with no supervision by school personnel.

Signature _____ Date _____

**Parent/Guardian Independent Carry and Use Permission (If Ordered by Provider Above):** I agree my child can self-administer this rescue medication effectively and may carry and use this medication independently at school with no supervision by school personnel.

Signature _____ Date _____



COPY FOR PATIENT

# 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-administrating 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.