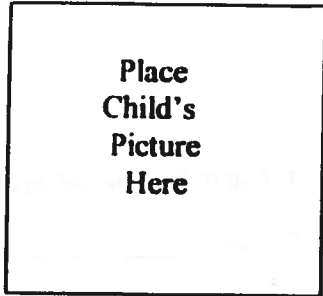


**ROXBURY TOWNSHIP PUBLIC SCHOOLS
Anaphylaxis Action Plan**



Student's Name: _____ D.O.B.: _____ Teacher: _____

ALLERGY TO: _____

Asthmatic Yes* No *Higher risk for severe reaction

◆ STEP 1: TREATMENT ◆

<u>Symptoms:</u>	<u>Give Checked Medication**:</u> **(To be determined by physician authorizing treatment)																
<ul style="list-style-type: none"> • If a food allergen has been ingested, but <i>no symptoms</i>: • Mouth Itching, tingling, or swelling of lips, tongue, mouth • Skin Hives, itchy rash, swelling of the face or extremities • Gut Nausea, abdominal cramps, vomiting, diarrhea • Throat+ Tightening of throat, hoarseness, hacking cough • Lung+ Shortness of breath, repetitive coughing, wheezing • Heart+ Weak or thready pulse, low blood pressure, fainting, pale, blueness • Other+ _____ • If reaction is progressing (several of the above areas affected), give 	<table border="0"> <tr> <td><input type="checkbox"/> Epinephrine</td> <td><input type="checkbox"/> Antihistamine</td> </tr> <tr> <td><input type="checkbox"/> Epinephrine</td> <td><input type="checkbox"/> Antihistamine</td> </tr> <tr> <td><input type="checkbox"/> Epinephrine</td> <td><input type="checkbox"/> Antihistamine</td> </tr> <tr> <td><input type="checkbox"/> Epinephrine</td> <td><input type="checkbox"/> Antihistamine</td> </tr> <tr> <td><input type="checkbox"/> Epinephrine</td> <td><input type="checkbox"/> Antihistamine</td> </tr> <tr> <td><input type="checkbox"/> Epinephrine</td> <td><input type="checkbox"/> Antihistamine</td> </tr> <tr> <td><input type="checkbox"/> Epinephrine</td> <td><input type="checkbox"/> Antihistamine</td> </tr> <tr> <td><input type="checkbox"/> Epinephrine</td> <td><input type="checkbox"/> Antihistamine</td> </tr> </table>	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
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+ Potentially life-threatening. The severity of symptoms can quickly change.

DOSAGE - Numerically state the order in which these medications are to be administered.

_____ **Epinephrine:** inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15mg
 *A trained delegate may only administer epinephrine, therefore if an antihistamine and epinephrine are ordered, the delegate may skip the antihistamine and administer epinephrine immediately for symptoms.

*A trained delegate may not administer a 2nd dose of epinephrine.

_____ Repeat X _____ in _____ minutes.

_____ **Antihistamine:** give _____
medication/dose/route

_____ **Other:** give _____
medication/dose/route

SELF-ADMINISTRATION*

- [] This student has been trained and is capable of self-administration of the following medication(s)
- Epinephrine – single dose unit
 - Epinephrine & antihistamine – single dose units

*Under NJ state law, orders for antihistamines alone cannot be self-administered.

[] This student is NOT capable of self-administration of the medications named above.

Physician's Signature _____

Date _____

Physician's Telephone _____

Physician's Providers Stamp:

◆ STEP 2: EMERGENCY CALLS ◆

1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Parent _____ Phone Number(s) cell _____
work _____
home _____
Parent _____ Phone Number(s) cell _____
work _____
home _____

IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR HAVE CHILD TRANSPORTED VIA RESCUE SQUAD TO NEAREST EMERGENCY MEDICAL FACILITY!

I verify that my child _____ has a potentially life threatening illness and has been instructed in self-administration of the prescribed medication in a life threatening situation. I hereby give my permission for my child to self-administer prescribed medication. I further acknowledge that the Roxbury Township School District shall incur no liability as a result of any injury arising from the self-administration of medication by my child, if procedures specified by NJ law and Roxbury Township School District policy are followed. I shall indemnify and hold harmless the Roxbury Township School District and it's employees or agents against any claims arising out of administration of medication to my child.

I give permission for a trained delegate, if available, to administer prescribed epinephrine to my child in the absence of the nurse.

PARENT/GUARDIAN PRINTED NAME

PARENT/GUARDIAN SIGNATURE

DATE

Asthma Treatment Plan

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

(Please Print)

The Pediatric/Adult
Asthma Coalition
of New Jersey

Your Pathway to Asthma Control
Original PACU approved Plan available at
www.pacnj.org

Sponsored by
**AMERICAN
LUNG
ASSOCIATION.**
of New Jersey



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

HEALTHY



Take daily medicine(s). All metered dose inhalers (MDI) to be used with spacers.



You have all of these:

- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work, exercise, and play

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
<input type="checkbox"/> Advair® 100, 250, 500	.....1 inhalation twice a day
<input type="checkbox"/> Advair® HFA 45, 115, 230	.....2 puffs MDI twice a day
<input type="checkbox"/> Asmanex® Twisthaler® 110, 220	.....1 - 2 inhalations a day
<input type="checkbox"/> Flovent® 44, 110, 220	.....2 inhalations twice a day
<input type="checkbox"/> Flovent® Diskus® 50 mcg	.....1 inhalation twice a day
<input type="checkbox"/> Pulmicort Flexhaler® 90, 180	.....1 - 2 inhalations once or twice a day
<input type="checkbox"/> Pulmicort Respules® 0.25, 0.5, 1.0	.....1 unit nebulized once or twice a day
<input type="checkbox"/> Qvar® 40, 80	.....2 inhalations twice a day
<input type="checkbox"/> Singulair 4, 5, 10 mg	.....1 tablet daily
<input type="checkbox"/> Symbicort® 80, 160	.....2 puffs MDI twice a day
<input type="checkbox"/> Other	

Remember to rinse your mouth after taking inhaled medicine.

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

Triggers

Check all items that trigger patient's asthma:

- Chalk dust
- Cigarette Smoke & 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, scented products
- Sudden temperature change
- Wood Smoke
- Foods:

CAUTION



Continue daily medicine(s) and add fast-acting medicine(s).



You have any of these:

- Exposure to known trigger
- Cough
- Mild wheeze
- Tight chest
- Coughing at night
- Other: _____

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
<input type="checkbox"/> Accuneb® 0.63, 1.25 mg	.....1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Albuterol 1.25, 2.5 mg	.....1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Albuterol <input type="checkbox"/> Pro-Air <input type="checkbox"/> Proventil®	.2 puffs MDI every 4 hours as needed
<input type="checkbox"/> Ventolin® <input type="checkbox"/> Maxair <input type="checkbox"/> Xopenex®	.2 puffs MDI every 4 hours as needed
<input type="checkbox"/> Xopenex® 0.31, 0.63, 1.25 mg	.....1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Increase the dose of, or add:	

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

- Other: _____
- _____
- _____
- _____

EMERGENCY



Take these medicines NOW and call 911. Asthma can be a life-threatening illness. Do not wait!



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

<input type="checkbox"/> Accuneb® 0.63, 1.25 mg	.....1 unit nebulized every 20 minutes
<input type="checkbox"/> Albuterol 1.25, 2.5 mg	.....1 unit nebulized every 20 minutes
<input type="checkbox"/> Albuterol <input type="checkbox"/> Pro-Air <input type="checkbox"/> Proventil®	.2 puffs MDI every 20 minutes
<input type="checkbox"/> Ventolin® <input type="checkbox"/> Maxair <input type="checkbox"/> Xopenex®	2 puffs MDI every 20 minutes
<input type="checkbox"/> Xopenex® 0.31, 0.63, 1.25 mg	.....1 unit nebulized every 20 minutes
<input type="checkbox"/> Other	

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

FOR MINORS ONLY:

- This student is capable and has been instructed in the proper method of self-administering of the inhaled medications named above in accordance with NJ Law.
- This student is not approved to self-medicate.

PHYSICIAN/APN/PA SIGNATURE _____ DATE _____

PARENT/GUARDIAN SIGNATURE _____

PHYSICIAN STAMP

Make a copy for patient and for physician file. For children under 18, send original to school nurse or child care provider.

The Pediatric/Adult Asthma Coalition of New Jersey, sponsored by the American Lung Association of New Jersey, and this plan are subject to a grant from the New Jersey Department of Health and Senior Services. Call for more information. (NJ) 2008-10-1. Contact for Update: Carol Ann (2008) or other. Copyright Agreement 2008-10-1. All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording, or by any information storage and retrieval system, without the prior written permission of the American Lung Association of New Jersey. It is not to be used for any other purpose. All other rights reserved. This document is the property of the American Lung Association of New Jersey and no other permission should be taken.

EFFECTIVE MARCH 2008
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Approved by the New Jersey Thoracic Society

ROXBURY TOWNSHIP SCHOOLS

PERMISSION FOR SELF-ADMINISTRATION OF MEDICATION
FOR POTENTIALLY LIFE-THREATENING ILLNESSES

NAME _____ DATE _____

SCHOOL _____ GRADE _____

MEDICATION _____

DOSAGE _____

GUIDELINES FOR ADMINISTRATION _____
(Please be specific)

I certify _____ suffers from
(student's name)
a potentially life-threatening illness _____
(condition)
and is capable of, and has been instructed in, the proper method of
self-administration of the above stated medication.

Physician's Printed Name Physician's Signature Date

To be completed by the parent/guardian:

I acknowledge that the Board of Education shall incur no liability as a result of any injury arising from the self-administration of medication by my child. I shall indemnify and hold harmless the district and its employees or agents against any claims arising out of the self-administration of medication by my child.

I give permission for _____
(student's name)
to self-administer _____
(medication)
as prescribed by his/her private physician.

Parent/Guardian Printed Name Parent/Guardian Signature Date

This permission form is effective only for the school year for which it is granted and must be renewed each school year.

ROXBURY TOWNSHIP PUBLIC SCHOOLS
HEALTH DEPARTMENT

NAME _____ DATE _____

SCHOOL EISENHOWER MIDDLE SCHOOL GRADE _____
47 EYLAND AVENUE
SUCCASUNNA, NJ 07876

ANNUAL UPDATE FOR MEDICAL CONDITIONS

In order for the health staff to provide optimum care for your child while attending school, it is vital that we have updated medical information submitted to the health office. Therefore, we would appreciate it if your doctor would complete the following form and return it to us by

_____ DATE _____

_____ NURSE'S SIGNATURE _____

Medical Diagnosis _____

Treatment _____

Medication _____

Recommendations for Physical Education _____

Restrictions/Limitations (other) _____

_____ DOCTOR'S PRINTED NAME _____

_____ DOCTOR'S SIGNATURE _____ DATE _____