American Lung Association.

My Asthma **Action Plan**
For Home and School

Office Stamp of Physician→ or Attach Official Letterhead of Physician

Name: _____ DOB: ____ / ____ / _____

Severity Classification: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Asthma Triggers (list): _____

Peak Flow Meter Personal Best: _____

Green Zone: Doing Well

Symptoms: Breathing is good – No cough or wheeze – Can work and play – Sleeps well at night
Peak Flow Meter _____ (more than 80% of personal best)

Flu Vaccine—Date received: _____ **Next flu vaccine due:** _____ **COVID19 vaccine—Date received:** _____

Control Medicine(s)	Medicine	How much to take	When and how often to take it	Take at
				☐ Home ☐ School
				☐ Home ☐ School

Physical Activity ☐ Use Albuterol/Levalbuterol ____ puffs, 15 minutes before activity ☐ with all activity ☐ when you feel you need it

Yellow Zone: Caution

Symptoms: Some problems breathing – Cough, wheeze, or tight chest – Problems working or playing – Wake at night
Peak Flow Meter _____ to _____ (between 50% and 79% of personal best)

Quick-relief Medicine(s) ☐ Albuterol/Levalbuterol ____ puffs, every 20 minutes for up to 4 hours as needed
Control Medicine(s) ☐ Continue Green Zone medicines
☐ Add _____ ☐ Change to _____

You should feel better within 20-60 minutes of the quick-relief treatment. If you are getting worse or are in the Yellow Zone for more than 24 hours, THEN follow the instructions in the RED ZONE and call the doctor right away!

Red Zone: Get Help Now!

Symptoms: Lots of problems breathing – Cannot work or play – Getting worse instead of better – Medicine is not helping
Peak Flow Meter _____ (less than 50% of personal best)

Take Quick-relief Medicine NOW! ☐ Albuterol/Levalbuterol ____ puffs, _____ (how frequently)

Call 911 immediately if the following danger signs are present:
- Trouble walking/talking due to shortness of breath
- Lips or fingernails are blue
- Still in the red zone after 15 minutes

School Staff: Follow the Yellow and Red Zone instructions for the quick-relief medicines according to asthma symptoms.
The only control medicines to be administered in the school are those listed in the Green Zone with a check mark next to "Take at School".

☐ Both the Healthcare Provider and the Parent/Guardian feel that the child has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

Healthcare Provider
Name _____ Date _____ Phone (____) ____ - _____ Signature _____

Parent/Guardian
☐ I give permission for the medicines listed in the action plan to be administered in school by the nurse or other school staff as appropriate.
☐ I consent to communication between the prescribing health care provider or clinic, the school nurse, the school medical advisor and school-based health clinic providers necessary for asthma management and administration of this medicine.

Name _____ Date _____ Phone (____) ____ - _____ Signature _____

School Nurse
☐ The student has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

Name _____ Date _____ Phone (____) ____ - _____ Signature _____

Please send a signed copy back to the provider listed above.

ROXBURY TOWNSHIP PUBLIC SCHOOLS

Succasunna, NJ

Medication Policy

Effective June 2020, Roxbury Township Board of Education adopted revised Policy #5330 regarding the administration of medication to students. According to the policy, "medication" means any prescribed or over-the-counter medicine. This includes such medications as Tylenol, aspirin or cough drops.

The following guidelines **must** be followed when the administration of medication in school is necessary:

1. The parent or guardian **and** private physician must provide a written request for the administration of the prescribed medication at school. The physician's written order must include the following:
    a. Name of the student
    b. Diagnosis or type of illness involved
    c. Name of the medication
    d. Dosage
    e. Time of administration
    f. Time when its use will be discontinued
    g. Side effects
2. Currently dated **medication must be brought to the Health Office by the parent/guardian in the original labeled containe**r. Most pharmacies will provide you with an extra bottle properly labeled for school.
3. Medication no longer required must be promptly removed by the parent/guardian.
4. Medication will only be administered to students in school by the school physician, a certified or non-certified school nurse, a substitute school nurse employed by the district or the student's parent/guardian. Students with asthma or other potentially life threatening illnesses will be allowed to self-administer medication when a nurse is not physically present at the scene. Permission for such administration must be on file in the office of the school nurse and comply with the conditions for granting permission.

Medication permission slips may be obtained from your school nurse or on-line at www.roxbury.org/Page/749.

Thank you for your attention to this matter.

ROXBURY SCHOOL DISTRICT | Medication Administration Daily Log (to be completed for each medication)

v.20231211

School Year *20* ____ / *20* ____ Student's School *(Underline/Circle)→* RHS EMS L/R Franklin Jefferson Kennedy Nixon

Name of Student _____ Date of Birth _____ Sex _____ Grade/Teacher _____

Parent/Guardian's signature granting permission for administration of medication/sharing of information with appropriate staff members:

Name of Parent/Guardian _____ ***Signature of Parent/Guardian*** _____ Date _____

Name & Dosage of Medication _____ Route _____ Time(s) Given in School _____

Start Date _____ End Date _____ *(Medication must be in the original container as dispensed by the pharmacy or physician)*

Reason for medication _____

Physician's Printed Name _____

Physician's signature _____ Date _____

Office Stamp of Physician → or Attach Official Letterhead of Physician

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Aug																															
Sep																															
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Dec																															
Jan																															
Feb																															
Mar																															
Apr																															
May																															
Jun																															

Initial & Signature of Person administering medication Codes^

1. _____ _____ _____
2. _____ _____ _____
3. _____ _____ _____
4. _____ _____ _____

(A) Absent
(O) No Show
(W) Dosage Withheld
(N) No Medication Available
(E) Early Dismissal
(F) Field Trip
(X) No School (e.g. Holiday; Weekend; Snow Day; etc.)

^See reverse side for reporting significant information.

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

Date	Explanation (with Signature)	Date	Explanation (with Signature)

ROXBURY SCHOOL DISTRICT | Permission for Self-Administration of Medication for Potentially Life-Threatening Illness

v.20250613-1015

School Year *20* ____ / *20* ____ Student's School *(Underline/Circle)→* RHS EMS L/R

Name of Student _____ Date of Birth _____ Sex _____ Grade/Teacher _____

Name of Medication _____

Dosage of Medication _____

Guidelines for Administration *(Please be specific)* _____

_____

Possible Side Effects _____

Start Date _____ End Date _____ *(Medication must be in the original container as dispensed by the pharmacy or physician)*

I certify _____ suffers from a potentially life-threatening illness _____
(Student's Name) *(Condition)*

and: ■ is capable of, and has been instructed in, the proper method of self-administration of the above stated medication; ■ is physically fit to attend school and is free of contagious disease; and ■ the medication must be administered during the school day or the student would not be able to attend school.

Physician's Printed Name _____

Physician's signature _____ Date _____

Office Stamp of Physician → or Attach Official Letterhead of Physician

Parent/Guardian's signature granting permission for self-administration of medication/sharing of information with appropriate staff members:

I hereby give consent for the disclosure of the information contained in the Action Plan for my student for the above described Potentially Life-Threatening Illness to all staff who may be involved in the implementation of the plan and to other appropriate staff. I acknowledge that the school district shall incur no liability as a result of any injury arising from the self-administration of medication by my child and that I 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 my child.

I give permission for _____ to self-administer _____ as prescribed by his/her physician.
(Student's Name) *(Medication)*

Name of Parent/Guardian _____ ***Signature of Parent/Guardian*** _____ Date _____

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