WEST ESSEX REGIONAL SCHOOLS

Asthma Treatment Plan

Part 1: To be completed by Physician

Student's Name:_____ D.O.B._____ Grade (in September)_____

Asthma Triggers

- ☐ Cold/Flu
- ☐ Exercise
- ☐ Allergens-Dust Mites/Pollen/Mold/Pet Dander/Pests
- ☐ Odors/Irritants-Cigarette Smoke/Second Hand Smoke/Perfumes/Cleaning Products
- ☐ Weather-Sudden Temperature Changes/Ozone Alert Days/Extreme hot and cold weather

For Exercise Induced Asthma take(medication)_____ _____Puffs _____Minutes prior to exercise.

Quick Relief Medication

For Cough, Mild Wheeze, Chest Tightness, Coughing Spacer Required YES NO (Supplied by Parent)

- ☐ Albuterol/Pro-Air/Proventil/Ventolin MDI _____puffs every 4 hours as needed
- ☐ Xopenex _____puffs every 4 hours as needed
- ☐ Symbicort ____puffs every 4 hours as needed
- ☐ Airsupra _____puffs every 4 hours as needed
- ☐ 0ther_____

For Bronchospasm

If quick relief medication did not help within 15-20 minutes, Breathing is hard or fast, Nasal Flaring, Intercostal Retractions, Tripoding, Cyanosis

- ☐ Albuterol MDI _____puffs every 20 minutes
- ☐ Xopenex _____4 puffs every 20 minutes
- ☐ Albuterol Nebulizer _____MG 1 unit nebulized every 20 minutes
- ☐ Xopenex _____MG 1 unit nebulized every 20 minutes
- ☐ DuoNeb 1 unit nebulized every 20 minutes
- ☐ Other_____

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 medication named above in accordance with NJ Law.

_____This student is NOT approved to self-medicate.

Parent/Caregiver Signature:_____Date:_____

Doctor's Signature:_____Date:_____

Office Stamp Required

ALL MEDICATION ORDERS EXPIRE ON THE LAST DAY OF THE SCHOOL YEAR

NEW ORDERS ARE REQUIRED EACH SEPTEMBER

Revised 10/2025

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.

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 the 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 the 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