

EDISON BOARD OF EDUCATION  
 EDISON, NEW JERSEY 08837  
 HEALTH SERVICES

**PARENT/GUARDIAN AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATION**

School: \_\_\_\_\_ School Year: \_\_\_\_\_

Grade/Level: \_\_\_\_\_ Homeroom: \_\_\_\_\_

1. We/I **(Circle)**, the undersigned parents(s)/guardian(s) **(Circle)** of \_\_\_\_\_  
**(Name of student)**

authorize the Edison Board of Education to permit our child to carry on his/her person and self-administer his/her own medication identified as follows:

\_\_\_\_\_  
**(Name of Medication )**

2. Attached hereto is the Asthma Action Plan written certification of \_\_\_\_\_,  
**(Name of Healthcare Provider)**

healthcare provider for the child noted above that the child has asthma, which is a potentially life-threatening illness. Our child is capable of, and has been instructed in, the proper method of self-administration of the medication identified above.

3. I/We **(Circle)** acknowledge that the Edison School District shall incur no liability as a result of any injury arising from the self-administration of medication(s) by the child noted above and I/We **(Circle)** shall identify and hold harmless the Edison School District and its employees or agents against any claims arising out of the self-administration of medication by the child noted above.

4. This authorization is effective for the 20\_\_ - 20\_\_ school year.

\_\_\_\_\_  
**(Print name of parent/guardian)**

\_\_\_\_\_  
**(Print name of parent/guardian)**

\_\_\_\_\_  
**(Signature of parent/guardian)**

\_\_\_\_\_  
**(Signature of parent/guardian)**

\_\_\_\_\_  
**(Date)**

5. I take responsibility for proper use and safe handling of my medication. I understand that improper or unsafe use or handling of medication may revoke my self-administration privileges.

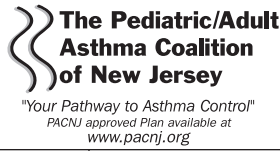
**Student signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Student is responsible for safe and appropriate self-administration of medication.**  
**Asthma medication self-administration may be denied if safety for self or others is compromised.**

# Asthma Treatment Plan

(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

## 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
<input type="checkbox"/> Advair® <input type="checkbox"/> 100, <input type="checkbox"/> 250, <input type="checkbox"/> 500 _____	1 inhalation twice a day
<input type="checkbox"/> Advair® HFA <input type="checkbox"/> 45, <input type="checkbox"/> 115, <input type="checkbox"/> 230 _____	2 puffs MDI twice a day
<input type="checkbox"/> Alvesco® <input type="checkbox"/> 80, <input type="checkbox"/> 160 _____	<input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs MDI twice a day
<input type="checkbox"/> Asmanex® Twisthaler® <input type="checkbox"/> 110, <input type="checkbox"/> 220 _____	<input type="checkbox"/> 1, <input type="checkbox"/> 2 inhalations <input type="checkbox"/> once or <input type="checkbox"/> twice a day
<input type="checkbox"/> Flovent® <input type="checkbox"/> 44, <input type="checkbox"/> 110, <input type="checkbox"/> 220 _____	2 puffs MDI twice a day
<input type="checkbox"/> Flovent® Diskus® <input type="checkbox"/> 50 <input type="checkbox"/> 100 <input type="checkbox"/> 250 _____	1 inhalation twice a day
<input type="checkbox"/> Pulmicort Flexhaler® <input type="checkbox"/> 90, <input type="checkbox"/> 180 _____	<input type="checkbox"/> 1, <input type="checkbox"/> 2 inhalations <input type="checkbox"/> once or <input type="checkbox"/> twice a day
<input type="checkbox"/> Pulmicort Respules® <input type="checkbox"/> 0.25, <input type="checkbox"/> 0.5, <input type="checkbox"/> 1.0 _____	1 unit nebulized <input type="checkbox"/> once or <input type="checkbox"/> twice a day
<input type="checkbox"/> Qvar® <input type="checkbox"/> 40, <input type="checkbox"/> 80 _____	<input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs MDI twice a day
<input type="checkbox"/> Singulair <input type="checkbox"/> 4, <input type="checkbox"/> 5, <input type="checkbox"/> 10 mg _____	1 tablet daily
<input type="checkbox"/> Symbicort® <input type="checkbox"/> 80, <input type="checkbox"/> 160 _____	<input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs MDI twice a day
<input type="checkbox"/> Other _____	
<input type="checkbox"/> None	

*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:

Other: \_\_\_\_\_

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

## 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
<input type="checkbox"/> Accuneb® <input type="checkbox"/> 0.63, <input type="checkbox"/> 1.25 mg _____	1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Albuterol <input type="checkbox"/> 1.25, <input type="checkbox"/> 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® <input type="checkbox"/> 0.31, <input type="checkbox"/> 0.63, <input type="checkbox"/> 1.25 mg _____	1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Increase the dose of, or add:	
<input type="checkbox"/> Other _____	

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

## 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!**

<input type="checkbox"/> Accuneb® <input type="checkbox"/> 0.63, <input type="checkbox"/> 1.25 mg _____	1 unit nebulized every 20 minutes
<input type="checkbox"/> Albuterol <input type="checkbox"/> 1.25, <input type="checkbox"/> 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® <input type="checkbox"/> 0.31, <input type="checkbox"/> 0.63, <input type="checkbox"/> 1.25 mg _____	1 unit nebulized every 20 minutes
<input type="checkbox"/> Other _____	

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### 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.

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.