



Oradell Public School District

350 Prospect Avenue | Oradell, NJ 07649 | oradellschool.org | (201)261-1180

*Our children,
our hope,
our future*

August 2020

Re: Nurse's Office Medication Paperwork for Students Entering Pre-K to 6th Grade for the 2020-2021 School Year

Dear Parent/Guardian,

Attached are the forms and paperwork required to be completed for students in grades Pre-K to 6th grade in September 2020.

This packet of information includes the following:

- Medication Form Checklist
- 2020-2021 Allergy Questionnaire
- Asthma Treatment Plan – Student
- Food Allergy & Anaphylaxis Emergency Care Plan
- Epi-Pen Authorization

Please return the new paperwork and medication to the Nurse's Office as soon as possible.

If you have any questions, please call me.

Thank you,

Gina Marana, BSN, RN
School Nurse
Oradell Public School
201-261-1180 ext. 4121
Fax: 201-634-1412
Email: nurse@oradellschool.org

Medication Form Checklist

August 2020

The following forms are to be completed by your doctor:

- Asthma Treatment Plan – Please attach a current photo of your child to this form.
- Food or Allergy Action Plan – This form is regarding allergies. Please attach current photo of your child to this form.

The following forms are to be completed by the parent/guardian:

- Allergy Questionnaire
- Epi-Pen Authorization Form

These forms need to be dated for the 2020-2021 school year.

The medication(s) and forms should be given to me as soon as possible.

Please contact the nurse's office to obtain a form for self-administration of medication by students at school.

If you have any questions, please call me.

Thank you,

Gina Marana, BSN, RN
School Nurse
Oradell Public School
201-261-1180 ext. 4121
Fax: 201-634-1412

**ORADELL PUBLIC SCHOOL
350 Prospect Avenue
Oradell, NJ 07649**

***Allergy Questionnaire
2020-2021 School Year***

Child's Name: _____ **Date of Birth:** _____ **Grade:** _____

What is your child allergic to? Is the allergy from eating only or is contact, touching, or smelling a concern?

Describe the reaction your child had (i.e., rash, itching, swelling, cough, trouble breathing, nausea).

Has your child been tested for allergies? List the allergens he/she is positive for.

When did your child have the last allergic reaction? To what was it attributed?

How was it treated? Medications given? Was a hospital visit needed?

Did your child have an anaphylactic incident? Please list the symptoms.

Please list the medications your child is presently taking. Include over the counter meds.

Does your child have an Epinephrine auto-injector or Auvi Q? YES NO

My child needs to sit at the nut free table.

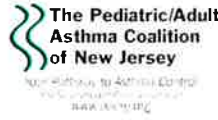
My child does not need to sit at the nut free table.

Parent Signature _____ **Date** _____

****Please attach lab results with allergy levels***

Asthma Treatment Plan – Student

(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 (Green Zone)



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 control medicine(s). Some 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® HFA <input type="checkbox"/> 45, <input type="checkbox"/> 115, <input type="checkbox"/> 230	2 puffs twice a day
<input type="checkbox"/> Aerospan™	<input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs twice a day
<input type="checkbox"/> Alvesco® <input type="checkbox"/> 80, <input type="checkbox"/> 160	<input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs twice a day
<input type="checkbox"/> Dulera® <input type="checkbox"/> 100, <input type="checkbox"/> 200	2 puffs twice a day
<input type="checkbox"/> Flovent® <input type="checkbox"/> 44, <input type="checkbox"/> 110, <input type="checkbox"/> 220	2 puffs twice a day
<input type="checkbox"/> Qvar® <input type="checkbox"/> 40, <input type="checkbox"/> 80	<input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs twice a day
<input type="checkbox"/> Symbicort® <input type="checkbox"/> 80, <input type="checkbox"/> 160	<input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs twice a day
<input type="checkbox"/> Advair Diskus® <input type="checkbox"/> 100, <input type="checkbox"/> 250, <input type="checkbox"/> 500	1 inhalation 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® 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® (Budesonide) <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"/> Singulair® (Montelukast) <input type="checkbox"/> 4, <input type="checkbox"/> 5, <input type="checkbox"/> 10 mg	1 tablet daily
<input type="checkbox"/> Other	
<input type="checkbox"/> None	

Remember to rinse your mouth after taking inhaled medicine.

If exercise triggers your asthma, take _____ puff(s) _____ minutes before exercise.

Triggers

- Check all items that trigger patient's asthma:
- Colds/flu
 - Exercise
 - Allergens
 - Dust Mites, dust, stuffed animals, carpet
 - Pollen - trees, grass, weeds
 - Mold
 - Pets - animal dander
 - Pests - rodents, cockroaches
 - Odors (Irritants)
 - Cigarette smoke & second hand smoke
 - Perfumes, cleaning products, scented products
 - Smoke from burning wood, inside or outside
 - Weather
 - Sudden temperature change
 - Extreme weather - hot and cold
 - Ozone alert days
 - Foods:
 - _____
 - _____
 - _____
 - Other:
 - _____
 - _____
 - _____

CAUTION (Yellow Zone)



You have **any** of these:

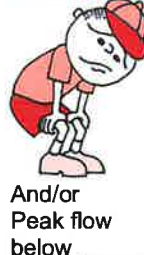
- Cough
- Mild wheeze
- Tight chest
- Coughing at night
- Other: _____

If quick-relief medicine does not help within 15-20 minutes or has been used more than 2 times and symptoms persist, call your doctor or go to the emergency room.
And/or Peakflow from _____ to _____

Continue daily control medicine(s) and ADD quick-relief medicine(s).

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
<input type="checkbox"/> Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	2 puffs every 4 hours as needed
<input type="checkbox"/> Xopenex®	2 puffs 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"/> Duoneb®	1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Xopenex® (Levalbuterol) <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"/> Combivent Respimat®	1 inhalation 4 times a day
<input type="checkbox"/> Increase the dose of, or add:	
<input type="checkbox"/> Other	
• If quick-relief medicine is needed more than 2 times a week, except before exercise, then call your doctor.	

EMERGENCY (Red Zone)



Your asthma is **getting worse fast:**

- Quick-relief medicine did not help within 15-20 minutes
- Breathing is hard or fast
- Nose opens wide • Ribs show
- Trouble walking and talking
- Lips blue • Fingernails blue
- Other: _____

And/or Peak flow below _____

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

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
<input type="checkbox"/> Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	4 puffs every 20 minutes
<input type="checkbox"/> Xopenex®	4 puffs 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"/> Duoneb®	1 unit nebulized every 20 minutes
<input type="checkbox"/> Xopenex® (Levalbuterol) <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"/> Combivent Respimat®	1 inhalation 4 times a day
<input type="checkbox"/> Other	

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

Read all directions. The use of this Healthy/PAHO Asthma Treatment Plan and its contents is at your own risk. This content is provided on an "as is" basis. The American Lung Association of the Mid-Atlantic (ALA-MA), The Pediatric/Adult Asthma Coalition of New Jersey and all affiliate chapters do not warrant, express or implied, accuracy or otherwise, including but not limited to, management, treatment, or medication, or management of education, signs, and symptoms of asthma. ALA-MA makes no representation or warranty about the accuracy, reliability, completeness, currency, or timeliness of the content. ALA-MA makes no warranty, representation or implied or explicit that the information will be useful or applicable to any individual case or condition. In the event of an ALA-MA related injury or damage, including but not limited to, negligence, malpractice, or other legal claims, the user hereby releases, defends, and holds ALA-MA harmless from and against all such claims, damages, costs, and expenses, including reasonable attorneys' fees, in any state or federal court. ALA-MA and its affiliates are not liable for any damages, including but not limited to, consequential or punitive damages, ALA-MA and its affiliates are not liable for any damages, including but not limited to, consequential or punitive damages, ALA-MA and its affiliates are not liable for any damages, including but not limited to, consequential or punitive damages.

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 medications named above in accordance with NJ Law.

This student is not approved to self-medicate.

PHYSICIAN/APN/PA SIGNATURE _____ DATE _____

Physician's Orders

PARENT/GUARDIAN SIGNATURE _____

PHYSICIAN STAMP _____

Make a copy for parent and for physician file, send original to school nurse or child care provider.

Asthma Treatment Plan – Student Parent Instructions



The PACNJ Asthma Treatment Plan is designed to help everyone understand the steps necessary for the individual student to achieve the goal of controlled asthma.

- 1. Parents/Guardians:** Before taking this form to your Health Care Provider, complete the top left section with:
 - Child's name
 - Child's date of birth
 - Child's doctor's name & phone number
 - An Emergency Contact person's name & phone number
 - Parent/Guardian's name & phone number
- 2. Your Health Care Provider will complete the following areas:**
 - The effective date of this plan
 - The medicine information for the Healthy, Caution and Emergency sections
 - Your Health Care Provider will check the box next to the medication and check how much and how often to take it
 - Your Health Care Provider may check "OTHER" and:
 - ✓ Write in asthma medications not listed on the form
 - ✓ Write in additional medications that will control your asthma
 - ✓ Write in generic medications in place of the name brand on the form
 - Together you and your Health Care Provider will decide what asthma treatment is best for your child to follow
- 3. Parents/Guardians & Health Care Providers together will discuss and then complete the following areas:**
 - Child's peak flow range in the Healthy, Caution and Emergency sections on the left side of the form
 - Child's asthma triggers on the right side of the form
 - Permission to Self-administer Medication section at the bottom of the form: Discuss your child's ability to self-administer the inhaled medications, check the appropriate box, and then both you and your Health Care Provider must sign and date the form
- 4. Parents/Guardians:** After completing the form with your Health Care Provider:
 - Make copies of the Asthma Treatment Plan and give the signed original to your child's school nurse or child care provider
 - Keep a copy easily available at home to help manage your child's asthma
 - Give copies of the Asthma Treatment Plan to everyone who provides care for your child, for example: babysitters, before/after school program staff, coaches, scout leaders

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 ON THE FRONT OF THIS FORM.

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 this 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 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/her asthma medication.

Parent/Guardian Signature

Phone

Date



Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: Yes (higher risk for a severe reaction) No

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

THEREFORE:

- If checked, give epinephrine immediately if the allergen was **LIKELY** eaten, for ANY symptoms.
- If checked, give epinephrine immediately if the allergen was **DEFINITELY** eaten, even if no symptoms are apparent.

FOR ANY OF THE FOLLOWING:
SEVERE SYMPTOMS



LUNG

Shortness of breath, wheezing, repetitive cough



HEART

Pale or bluish skin, faintness, weak pulse, dizziness



THROAT

Tight or hoarse throat, trouble breathing or swallowing



MOUTH

Significant swelling of the tongue or lips



SKIN

Many hives over body, widespread redness



GUT

Repetitive vomiting, severe diarrhea



OTHER

Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.
 - Consider giving additional medications following epinephrine:
 - » Antihistamine
 - » Inhaler (bronchodilator) if wheezing
 - Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
 - If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
 - Alert emergency contacts.
 - Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS



NOSE

Itchy or runny nose, sneezing



MOUTH

Itchy mouth



SKIN

A few hives, mild itch



GUT

Mild nausea or discomfort

FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA, GIVE EPINEPHRINE.

FOR MILD SYMPTOMS FROM A SINGLE SYSTEM AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: 0.1 mg IM 0.15 mg IM 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE _____

DATE _____

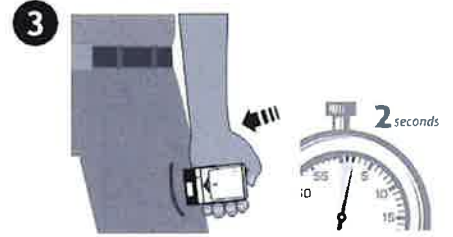
PHYSICIAN/HCP AUTHORIZATION SIGNATURE _____

DATE _____



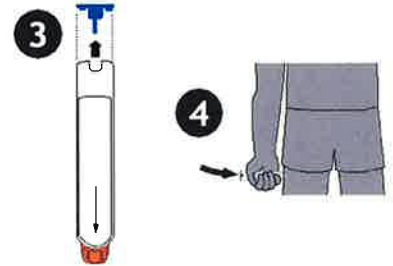
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
5. Call 911 and get emergency medical help right away.



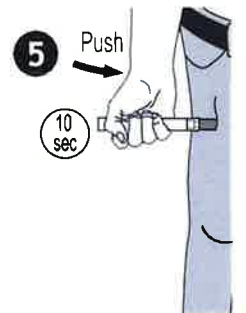
HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENALCLICK®), USP AUTO-INJECTOR, IMPAX LABORATORIES

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip.
3. Grasp the auto-injector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. Call 911 and get emergency medical help right away.



ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS – CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

ORADELL PUBLIC SCHOOL
350 Prospect Avenue
Oradell, NJ 07649

EPI-PEN AUTHORIZATION

To be completed by Parent/Guardian:

A current single dose Epinephrine auto-injector must be provided to the school for your child's use. All antihistamines and epinephrine must be brought to school by an adult and be provided in the original container.

Select one to sign and date:

I verify that my child, _____, has a potentially life-threatening illness and is **unable to self-administer the prescribed medication** in a life threatening situation. **I hereby request the school nurse or delegate (if applicable) to administer the prescribed medication to my child.** I further acknowledge that the Oradell Public School District shall incur no liability as a result of any injury arising from administration of medication to my child. If procedures are specified by NJ law and Oradell Public School District Policy (additional paperwork must be obtained from the nurse and completed according to District Policy) are followed. I shall indemnify and hold harmless the Oradell Public School District and its employees or agents against any claims arising out of administration of medication to my child.

(Signature of Parent/Guardian)

(Date)

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 permission for my child to self-administer prescribed medication.** I further acknowledge that the Oradell Public School District shall incur no liability as a result of any injuring arising from the self-administration of medication by my child. If procedures specified by NJ law and Oradell Public School District policy (additional paperwork must be obtained from the nurse and completed according to District policy) are followed, I shall indemnify and hold harmless the Oradell Pubic School District and its employees or agents against any claims arising out of self-administration of medication by my child. NJ State Assembly Act 2600 directs that students may be permitted to self-administer medication for asthma and potentially life-threatening illnesses or a life-threatening allergic reaction, provided proper procedures are followed.)

(Signature of Parent/Guardian)

(Date)

SCHOOL USE ONLY:

Please sign:

I understand that under NJ State law, a **trained delegate will be assigned to administer epinephrine** to my child in **the absence of a school nurse.** Antihistamines may not be given by a delegate. In the absence of a school nurse, any antihistamine order will be disregarded and epinephrine will be administered by a trained delegate.

(Signature of Parent/Guardian)

(Date)

(Signature of Principal)

(Date)