Church of Saint Dominic
OFFICE OF RELIGIOUS EDUCATION
250 OLD SQUAN ROAD, BRICK, NEW JERSEY 08724-3224
732-840-1414

Medication/Treatment Authorization Form

Student: D.O.B.:

Teacher: Grade:

PARENTAL REQUEST

I, the parent/guardian of_____, requests that the school nurse administer the medication prescribed by my child's physician to my child at the prescribed time.

I understand that I will need to bring the medication to the school nurse on behalf of my child. The medication will be brought to school in its original container appropriately labeled by my pharmacy.

Signature of Parent/Guardian

Date

PHYSICIAN'S STATEMENT

In order to protect the health of

It is necessary for her/him to have the following medication during school hours.

Medication:

Dosage:

Time to be administered:

Purpose of medication:

List any possible side effects that might be expected:

Diagnosis:

I authorize the school nurse to administer the above medication.

Signature of Physician Date

Print Physician Name Date

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ALLERGY INFORMATION FORM

Parent/Guardian: Please complete this form and return it to the School Health Room.

Child's Name _____ Grade _____

School _____ ;_____ Date_____

TYPE OF ALLERGY

Check the box next to any allergy your child has experienced and list name/s as requested:

□ Medication student is allergic to:_____ □ Name of specific food:_____

□ Environmental allergens Insect dust, mites, mold, pets, etc._____

□ Insect bites/stings_____

SYMPTOMS OF ALLERGY

Check the line next to any symptoms your child has experienced:

__ Hives or giant hives
__ Swelling of_____
__ Difficulty in breathing - wheezing
__ Difficulty swallowing
__ Shock
__ Fainting - dizziness
__ Other (Describe) _
_____

1. Has your child seen a doctor for any of the allergies indicated above? Yes □ No □
2. Has your child ever been hospitalized for any allergic event? Yes □ No □
   Describe
3. Is medication required immediately after exposure to any allergy producing substance?
   Yes □ No □
   If Yes, name of medication _____
   (Please note: we must have both the *medication and* the signed *Medication/Treatment Authorization Form* on file in order to administer the medication.)
4. If no medication is necessary, how should the school treat the allergic event?
   Careful observation Yes □ No □ Call parent/guardian Yes □ No □

If dietary changes are medically necessary, a Doctor's order with diagnosis is required.

COMMENTS:_ _____

Parent/Guardian's Name_ _____ Phone#_____

Parent/Guardian's Signature _____ Date _____

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Epinephrine Administration

Student_____Grade_____DOB_____

As parent/guardian, I request the administration of epinephrine via a pre-filled single dose auto-injector mechanism. Attached are the physician's orders requiring the administration of epinephrine to my child in the event of an emergency. I will provide a current pre-filled auto injector to the nurse's office. If the school nurse is unavailable, then a trained designee will administer the epinephrine.

As parent/guardian, I understand that the school and its employees will have no liability as a result to any injury arising from the administration or failure to administer epinephrine to the student.

_____ _____

Parent/Guardian Signature Date

Asthma Treatment Plan

(This asthma action plan meets N.J. Law N.J.S.A. 18A:40-12.6) (Physician's Orders)

The Pediatric/Adult Asthma Coalition of New Jersey
"Your Pathway to Asthma Control"
Sponsored by AMERICAN LUNG ASSOCIATION.

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

Remember to rinse your mouth after taking inhaled medicine.

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

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
☐ Accuneb® ☐ 0.63, ☐ 1.25 mg	1 unit nebulized every 4 hours as needed
☐ Albuterol ☐ 1.25, ☐ 2.5 mg	1 unit nebulized every 4 hours as needed
☐ Albuterol ☐ Pro-Air ☐ Proventil®	2 puffs MDI every 4 hours as needed
☐ Ventolin® ☐ Maxair ☐ Xopenex®	2 puffs MDI every 4 hours as needed
☐ Xopenex® ☐ 0.31, ☐ 0.63, ☐ 1.25 mg	1 unit nebulized every 4 hours as needed
☐ Increase the dose of, or add:	
☐ 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!

☐ Accuneb® ☐ 0.63, ☐ 1.25 mg	1 unit nebulized every 20 minutes
☐ Albuterol ☐ 1.25, ☐ 2.5 mg	1 unit nebulized every 20 minutes
☐ Albuterol ☐ Pro-Air ☐ Proventil®	2 puffs MDI every 20 minutes
☐ Ventolin® ☐ Maxair ☐ Xopenex®	2 puffs MDI every 20 minutes
☐ Xopenex® ☐ 0.31, ☐ 0.63, ☐ 1.25 mg	1 unit nebulized every 20 minutes
☐ Other	

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.

REVISED MAY 2008

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.

Save Print