CAMDEN CO. DEPT. OF HEALTH & HUMAN SERVICES
SCHOOL HEALTH PROGRAM

Dear Parent:

In order to be able to better treat your child's asthma, we ask that you provide an updated asthma action plan for the new school year. A new medication form completed by you and your doctor is also required each school year. Please be sure your doctor indicates whether or not your child has permission to carry and self-administer an inhaler. If your child does carry an inhaler it is important that one also be provided for the school office.

There is a nebulizer available for use in the nurse's office. In order for your child to use it, we must have a medication form completed by your doctor with the name of the medication, dose and frequency. The form must also be signed by a parent or guardian. The tubing for the nebulizer must be provided along with the medication.

Please return the completed forms before the first day of school.

Thank You,
Patricia DeDomenico, R.N.
School Nurse

Camden County Department of Health & Human Services

STUDENT ASTHMA ACTION CARD

Name_____ Grade_____ Teacher_____

Parent/Guardian_____ Phone (Home)_____ Work_____

Parent/Guardian_____ Phone (Home)_____ Work_____

Emergency Contact #1_____
Name Relationship Phone

Emergency Contact #2_____
Name Relationship Phone

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DAILY ASTHMA MANAGEMENT PLAN

- Identify triggers for asthma attack (check each that applies to the student.)

____Exercise	____Strong odors or fumes	___Animals
____Respiratory infections	____Chalk dust	____Pollens
____Change in temperature	___ Carpets in a room	____Food
____Molds		

Comments_____

- Control of School Environment
  List any environmental control measures, pre-medications, and/or dietary restrictions that will help prevent an asthma episode _____
  _____
- Peak Flow Monitoring
  Personal best peak flow number _____
  Monitoring times_____

Daily Medication Plan

Name	Dose	When to use
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____

****

Physician's Signature_____ Date_____

Parent/Guardian Signature_____ Date_____

Department Of Health and Human Services

Carmen G. Rodriquez
Freeholder Liaison
Patrick Shuttleworth
Deputy Director
Ann D. Biondi *Division Director*

camden county
Making It Better, Together.

Personal Health Services
Division of Health
School Nursing Program
700 Monmouth Street
Gloucester City, N.J. 08030
(856) 456-0475
Fax (856) 456-4090

Medication Administration in Schools

The following rules for the administration of medication in schools applies to BOTH prescription and non-prescription (e.g., Tylenol, cough syrup) medications in the school setting. No medication will be administered unless the following requirements are met.

1. ***A written order from the physician to include the name of the pupil, name of the medication, dosage, the time the medication is to be administered at school and length of time to be given.***
2. ***A written medication administration form completed by the parent/guardian releasing the school and the school personnel from any liability there of. Medications are administered by a school nurse or designated responsible person. Medication Administration forms are available at the school office and from the school nurse.***
3. ***Medications are to be delivered to the school by the parent/guardian or a designated responsible person.***
4. ***All medication must be in the original container and clearly labeled.***
5. ***Controlled medications (e.g. Ritalin) require a thirty-day physicians renewal.***
6. ***At the end of the school year, medications must be picked up at school by the parent/guardian. Any remaining medication will be destroyed.***
7. ***If self-administration of a medication is prescribed, the parent/guardian and the authorizing physician must complete the medication administration form.***

School personnel <u>shall not</u> provide pupils with any medication until all the requirements are met.

CAMDEN CO. DEPT. OF HEALTH & HUMAN SERVICES
SCHOOL HEALTH PROGRAM
MEDICATION ADMINISTRATION FORM

I request that the enclosed medication in the original container be administered to my child as prescribed, and shall release school personnel from all liability.

NAME OF CHILD _____ *GRADE* _____

NAME OF MEDICATION _____

DOSAGE _____

PURPOSE _____

_____

Parent/guardian signature *Date*

****

TO BE FILLED IN BY SCHOOL NURSE

Prescription # _____ *Date* _____

Pharmacy _____ *Phone #* _____ *Name of Medication* _____

Name of Physician _____ *Phone #* _____

 # OF TABLETS RECEIVED _____

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PHYSICIAN'S ORDERS

Name of Patient _____

Name of Medication _____

Date of Prescription _____

Dosage _____

Purpose _____

COMMENTS _____

_____

Doctor's Name (please print) *Doctor's Signature* *Date*