Newton High School Health Office

Student Asthma Treatment Plan

Dear Parent/Guardian,

I hope this message finds you well! According to our records, your child has a history of asthma. Because asthma can be a serious health condition, it's very important that we have the most accurate and up-to-date information on file to help ensure your child's safety while at school.

To update our records, we kindly ask that you complete and return the following:

Asthma Action Plan:

- This form must be completed **every academic school year** throughout your child's high school years.
- Please note that new forms will be valid beginning **July 1st** for the upcoming school year. Any forms dated before July 1st will **not** be accepted for the new school year.
- The **parent/guardian** must complete and sign the bottom portion.
- The **healthcare provider** must complete the entire form, sign, and stamp the bottom of the form.
- If your child is approved to self-carry and use their inhaler, the provider must clearly document this in the designated section of the form.
- The **parent/guardian** must complete and sign the bottom portion.
- The **healthcare provider** must complete the middle section, sign, and stamp the bottom of the form.
- If your child is approved to self-carry and use their inhaler, the provider must clearly document this in the designated section of the form.

If this information is no longer accurate and your child is **not currently prescribed an inhaler**, please have your child's pediatrician or healthcare provider write a letter on their office letterhead stating that your child no longer uses an inhaler.

Please submit all forms or provider letters as soon as possible. Incomplete or missing documentation may result in your child being unable to participate in certain school activities or events.

We understand this process can take time and appreciate your help in making sure we have the proper medical documentation on file. If you have any questions or need assistance, feel free to reach out at **973-383-7573 x3231**. Forms or letters can also be faxed to **973-383-2751**.

Thank you for your cooperation and partnership in keeping your child safe and healthy at school!

Warm Regards,

Nivek Zayas
MSN, RN, CSN- NJ
School Nurse
Newton High School
T: (973)-383-7573 Ext: 3231
F: (973)-383-2571

NEWTON PUBLIC SCHOOLS

Board of Education ♦ 57 Trinity Street ♦ Newton, NJ 07860 ♦ (973) 383-7392

Asthma Action Plan

Student Name:_____ DOB: _____

Diagnosis: _____ School Year:_____

Triggers may include (please check all that apply):

- ☐ Colds/Flu
- ☐ Allergens _____
- ☐ Odors _____
- ☐ Weather/Sudden Change in temperature
- ☐ Other:_____

Prescribed rescue medication for the above named student:

- ☐ Albuterol 2 puffs with space (90 mcg) or 1 vial (2.5 mg) via nebulization
- ☐ DuoNeb/Combivent 2 puffs with space (20 mcg/100 mcg) or 1 vial (2.5 mg) via nebulization
- ☐ Levalbuterol 2 puffs with spacer (45 mcg) or or 1 vial (0.63 mg) via nebulization
- ☐ Symbicort 2 puffs with spacer (80 mcg per puff)
- ☐ Other _____

When Needed:

- ☐ For cough, wheeze, shortness of breath and colds- give eerie 4 hours as needed.
- ☐ 15-30 minutes prior to exercise as needed
- ☐ Notify parents if symptoms persist
- ☐ If needed, may give medications every 30 minutes for THREE treatments.
- ☐ Call EMS if NOT improving.
- ☐ Other _____

Side Effects:

- ☐ Increased heart rate
- ☐ Facial flushing
- ☐ Jitteriness
- ☐ Other _____

Medication Use:

- ☐ Independently- The child has been trained and is proficient in self administration
- ☐ Under the supervision of the school nurse

Medication:

- ☐ Stored in the nurse's office.
- ☐ In the possession of the student

Physician's Signature & stamp _____ Date: _____

Parent's Signature _____ Date: _____

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PARENT/GUARDIAN PERMISSION TO RELEASE AND EXCHANGE CONFIDENTIAL INFORMATION

I hereby authorize an exchange of information between the School Health Services Nursing Staff and:

NAME: _____NHS STAFF_____ PHONE: ___973-383-7573__

ADDRESS : _____44 Ryerson Ave Newton NJ 07860_____

Regarding: _____ any or all information

__X___ specific information regarding: __Medical DX_____

contained in the record of:

_____ _____

STUDENT'S NAME DATE OF BIRTH

Newton High School

_____

SCHOOL

This authorization is in effect for one calendar year from today: _____

Signature of parent/guardian: _____

Preschool at Camp Auxilium
Gina Kithcart, RN,MSN, CSN
973-383-7202 x1331
gkithcart@newtonnj.org

Merriam Ave School
Michelle Kinney, RN,BSN,CSN
973-383-7202 x1231
mkinney@newtonnj.org

Halsted Middle School
Carol Marinaro, RN,BSN,CSN
973-383-7440 x2231
cmarinaro@newtonnj.org

Newton High School
Nivek Zayas, RN, MSN CSN
973-383-7573 x3231
nzayas@newtonnj.org

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OVER-THE-COUNTER MEDICATION ADMINISTRATION FORM

Dear Parent/Guardian,

If your physician decides it is necessary for your son/daughter to receive **over-the-counter medication** during the school day, the following procedures must be followed. This form must be completed by his/her physician and signed by the parent/guardian. This is only for the OTC medications listed below. If your son/daughter requires medication other than these please have your physician complete the Administration of Prescription Medication form. **The dosage/frequency must be completed by the physician.** This form will remain in effect for the entire school year.

Physician's Instructions for Over-the-Counter Medication in School

Student's Name: _____

Grade: _____

I request that the school nurse administer the following medication as prescribed below:

_____ Acetaminophen _____
Dosage / Frequency

_____ Ibuprofen _____
Dosage / Frequency

_____ Antacid _____
Dosage / Frequency

Physician's Stamp

Physician's Signature:_____ Date:_____

I give permission for the school nurse to dispense the above prescribed medication to my child.

_____ Date:_____
Parent/Guardian Signature

Preschool at Camp Auxilium
Gina Kithcart, RN,MSN, CSN
973-383-7202 x1331
gkithcart@newtonnj.org

Merriam Ave School
Michelle Kinney, RN,BSN,CSN
973-383-7202 x1231
mkinney@newtonnj.org

Halsted Middle School
Carol Marinaro, RN,BSN,CSN
973-383-7440 x2231
cmarinaro@newtonnj.org

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Nivek Zayas, RN, MSN CSN
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