

**MEDICATION ORDER**

**(TO BE GIVEN BY SCHOOL NURSE)**

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

No medication will be administered without BOTH the written order from the physician and the parent.

**PHYSICIAN, PLEASE NOTE:**  
**Do not leave any blank spaces.** This form will be returned to you and may cause a delay in the administration of your patient's medication.

Student Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Grade \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Dose: \_\_\_\_\_ Route: \_\_\_\_\_ Time(s): \_\_\_\_\_ Total dose(s) per day: \_\_\_\_\_

If PRN provide criteria: \_\_\_\_\_

Precautions/side effects, if any (i.e. No heights or climbing ladders, no waterway activities-risk of drowning, tc.):  
\_\_\_\_\_

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

Physician's name: \_\_\_\_\_ *Signature:* \_\_\_\_\_ Date: \_\_\_\_\_  
Printed

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Phone: \_\_\_\_\_

\*\*\*\*\*

**Parent/Guardian completes this section:**

I give permission for the school nurse to administer the above medication, as prescribed by my child's physician, to my child, \_\_\_\_\_. I understand that no medication will be given to my child unless it is brought to school in the original container, properly labeled, from the pharmacy/manufacturer

Parent/Guardian Print Name: \_\_\_\_\_

Parent/ Guardian *Signature:* \_\_\_\_\_

DATE: \_\_\_\_\_

**EMERGENCY HEALTH CARE PLAN**

Place  
Child's  
Picture  
Here

**ALLERGY TO:** \_\_\_\_\_

Student's Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ Teacher: \_\_\_\_\_

Asthmatic Yes \* No  \*High risk for severe reaction

**SIGNS OF AN ALLERGIC REACTION INCLUDE:**

- |                  |  |
|------------------|--|
| <b>Systems:</b>  | <b>Symptoms:</b>   |
| • <b>MOUTH</b>   | itching & swelling of the lips, tongue, or mouth                                 |
| • <b>THROAT*</b> | itching and/or a sense of tightness in the throat, hoarseness, and hacking cough |
| • <b>SKIN</b>    | hives, itchy rash, and/or swelling about the face or extremities                 |
| • <b>GUT</b>     | nausea, abdominal cramps, vomiting, and/or diarrhea                              |
| • <b>LUNG*</b>   | shortness of breath, repetitive coughing, and/or wheezing                        |
| • <b>HEART*</b>  | "thready" pulse, "passing-out"   |

The severity of symptoms can quickly change. \*All above symptoms can potentially progress to a life-threatening situation!

**ACTION:**

- If ingestion is suspected, give \_\_\_\_\_ medication/dose/route and \_\_\_\_\_ immediately!
- CALL RESCUE SQUAD: \_\_\_\_\_
- CALL: Mother \_\_\_\_\_ Father \_\_\_\_\_ or emergency contacts \_\_\_\_\_
- CALL: Dr. \_\_\_\_\_ at \_\_\_\_\_

**DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL RESCUE SQUAD EVEN IF PARENTS OR DOCTOR CANNOT BE REACHED!**

\_\_\_\_\_  
Parent Signature                      Date                      Doctor's Signature                      M.D.                      Date

EMERGENCY CONTACTS	TRAINED STAFF MEMBERS
1. _____ Relation: _____ Phone: _____	1. _____ Room _____
2. _____ Relation: _____ Phone: _____	2. _____ Room _____
3. _____ Relation: _____ Phone: _____	3. _____ Room _____



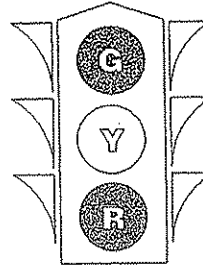
For children with multiple food allergies, use one form for each food. 5/95

# Asthma Action Plan

(Meets NJ Law N.J.S.A. 18A:40-12.8)

(Press Firmly)

Name	Date of Birth	Effective Date / / to / /
Doctor	Phone	
Parent/Guardian (if applicable)	Parent's Phone	
Emergency Contact	Contact Phone	



**Green means Go Zone!**  
Use prescribed green zone medicine.

**Yellow means Caution Zone!**  
Add prescribed yellow zone medicine.

**Red means Danger Zone!**  
Get help from a doctor.

The colors of a traffic light will help you use your asthma medicines.

## GO (Green)

- You have all of these:
- Breathing is good
  - No cough or wheeze
  - Sleep through the night
  - Can work and play

And/or Peak flow above \_\_\_\_\_



## CAUTION (Yellow)

- You have any of these:
- First sign of a cold
  - Exposure to known trigger
  - Cough
  - Mild wheeze
  - Tight chest
  - Coughing at night

And/or Peak flow from \_\_\_\_\_ to \_\_\_\_\_



## DANGER (Red)

Your asthma is getting worse fast:

- Medicine is not helping within 15-20 minutes
- Breathing is hard and fast
- Nose opens wide
- Ribs show
- Lips blue
- Fingernails blue
- Trouble walking and talking

And/or Peak flow below \_\_\_\_\_



## Use these medicines every day

MEDICINE	HOW MUCH TO TAKE	WHEN TO TAKE IT

For asthma with exercise, take:

--	--	--

## Continue with green zone medicine and ADD:

MEDICINE	HOW MUCH TO TAKE	WHEN TO TAKE IT
FIRST ➡		
NEXT ➡		

➡ IF QUICK RELIEVER MEDICINE IS NEEDED MORE THAN 2-3 TIMES A WEEK THEN CALL YOUR DOCTOR.

## Take these medicines and call your doctor NOW!

EMERGENCY MEDICINE	HOW MUCH TO TAKE	WHEN TO TAKE IT

## Get help from a doctor now! It's Important!

Asthma is a potentially life threatening illness. If you cannot contact your doctor, go directly to the emergency room. DO NOT WAIT. Make an appointment with your primary care provider within two days of an ER visit or hospitalization.

Check all items that trigger your asthma and things that could make your asthma worse:

- 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 product
- Sudden temperature change
- Wood Smoke
- Foods:
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- Other:
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**FOR MINORS ONLY:**

- This student is capable and has been instructed in the proper method of self-administering the medications named above.
- This student is not approved to self-medicate.

PHYSICIAN/APN/PA SIGNATURE \_\_\_\_\_ PARENT/GUARDIAN SIGNATURE \_\_\_\_\_

PHYSICIAN STAMP

Approved by the New Jersey Thoracic Society, Medical Section of the American Lung Association of New Jersey

Adapted from the NYC Childhood Asthma Initiative Adapted from the NIH

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