Name    Date of Birth	umber
Parent/Guardian  Phone  Alternate Phone  Alternate Phone  DIAGNOSIS OF ASTHMA SEVERITY  Intermittent Persistent Mild Moderate Severe Maint Measthma Work  GREEN ZONE: GO!  Take These DAILY CONTROLLER MEDICINES (PREVENTION) Medicines EVERY  You have ALL of these: Breathing is easy No cough or wheeze Can work and play Can sleep all night  Take puff(s) or tablet(s) daily. For asthma with exercise, ADD: puffs with spacer minutes before exercise ALWAYS RINSE YOUR MOUTH AFTER USING YOUR DAILY INHALED MEDICINE.  YELLOW ZONE: CAUTION!  Continue DAILY CONTROLLER MEDICINES and ADD QUICK-RELIEF Medicines	umber
Parent/Guardian/Alternate Emergency Contact    Phone   Alternate Phone	
DIAGNOSIS OF ASTHMA SEVERITY    Intermittent   Persistent   Mild   Moderate   Severe   Smoke   Colds   Exercise   Animals   Weather   Odors   Pollen   Other	
Intermittent Persistent [ Mild Moderate Severe ] Smoke Colds Exercise Animals Weather Odors Pollen Other   GREEN ZONE: GO! Take These DAILY CONTROLLER MEDICINES (PREVENTION) Medicines EVERY  You have ALL of these: Breathing is easy No cough or wheeze Can work and play Can sleep all night  Take puff(s) or tablet(s) daily. For asthma with exercise, ADD: puffs with spacer minutes before exercise ALWAYS RINSE YOUR MOUTH AFTER USING YOUR DAILY INHALED MEDICINE.  YELLOW ZONE: CAUTION!  Continue DAILY CONTROLLER MEDICINES and ADD QUICK-RELIEF Medicines	
You have ALL of these:  Breathing is easy  No cough or wheeze  Gan work and play  Can sleep all night  No daily controller medicines required  Daily controller medicine(s):  Take puff(s) or tablet(s) daily.  For asthma with exercise, ADD: minutes before exercise  ALWAYS RINSE YOUR MOUTH AFTER USING YOUR DAILY INHALED MEDICINE.  YELLOW ZONE: CAUTION!  Continue DAILY CONTROLLER MEDICINES and ADD QUICK-RELIEF Medicines	
Breathing is easy No cough or wheeze Can work and play Can sleep all night  Take puff(s) or tablet(s) daily. For asthma with exercise, ADD: minutes before exercise ALWAYS RINSE YOUR MOUTH AFTER USING YOUR DAILY INHALED MEDICINE.  YELLOW ZONE: CAUTION!  Continue DAILY CONTROLLER MEDICINES and ADD QUICK-RELIEF Medicines	DAY
You have ANY of these: Take daily controller medicine if ordered and add this quick-relief medicine when you have to	
Cough or mild wheeze Tight chest Shortness of breath Problems sleeping, working, or playing  Take	inhaler mcg  dren may need a mask. mg / ml hours, if needed.
RED ZONE: EMERGENCY! Continue DAILY CONTROLLER MEDICINES and QUICK-RELIEF Medicines and Q	GET HELP!
You have ANY of these:  Very short of breath  Medicine is not helping  Breathing is fast and hard  Nose wide open, ribs showing, can't talk well  Lips or fingernails are grey or bluish  Description:  Takepuffs everyhours, if needed. Always use a spacer, some chilenebulizernebulizernebulizernebulizer treatment every  Other  CALL HEALTH CARE PROVIDER AGAIN WHILE GIVING QUICK-RELIEF MEDICINE. If head be contacted, CALL 911 FOR AN AMBULANCE OR GO DIRECTLY TO THE EMERGENCY	mg / ml hours, if needed.
REQUIRED PERMISSIONS FOR ALL MEDICATION USE AT SCHOOL Health Care Provider Permission: I request this plan to be followed as written. This plan is valid for the school year	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
OPTIONAL PERMISSIONS FOR INDEPENDENT MEDICATION CARRY AND USE AT SCHOOL  Health Care Provider Independent Carry and Use Permission: I attest that this student has demonstrated to me that they can self-administer of effectively and may carry and use this medication independently at school with no supervision by school personnel.  Signature	
Parent/Guardian Independent Carry and Use Permission (If Ordered by Provider Above): I agree my child can self-administer this rescue med may carry and use this medication independently at school with no supervision by school personnel.  Signature	

## **AUTHORIZATION FOR ADMINISTRATION OF ASTHMA PRESCRIPTION MEDICATION**

## RECOMMENDATIONS ARE EFFECTIVE FOR THE CURRENT SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY

Student Name:		DOB:	Grade:	
Emergency Contacts: (Name a	and Phone#'s):			
I. Parental/Guardian CoI request that my child be pursuant to N.J.S.A. 18A:40-1 prescribed on this form for the storing and self-administrating no liability as a result of any corprescribed on this form. I indeparts out of self-administration arising out of self-administration.	e ALLOWED to carry an 2.3 and 12.4. I give perm current school year. I con the medication. I undersondition or injury arising firmnify and hold harmless	Id self-admini ission for my consider him/her tand that the srom the self-acthe School Dis	ster in school, his asthma na child to self-administer his/heit to be responsible and capable chool district, agents and its dministration by the student of strict, its agents and employed	r medication, as le of transporting, employees shall incur of the medication
I do not request that my taking the medication describe medication to students in schoof the medication is mine, and at another location at the time employees shall incur no liabil administration of the medication employees against any claims	ed below at school by the col pursuant to N.J.A.C:.6 I am fully aware that the that the medication is ne lity as a result of any concon prescribed on this form	School Nurse A:16-2.3. I un duties of the s eded. I unders dition or injury n. I indemnify a	derstand the ultimate respon school nurse and others may stand that the school district, arising from the administration and hold harmless the School	ed to administer sibility for administration require their presence agents and its on or lack of libits and li
Parent/Guardian Signature	Telephone		Date	
II. Healthcare Provider	Order:			
Name of medication:	×			
Dosage:				
For Student Self Administration:This student has been instr	ructed in and is capable of p he purpose, appropriate met	roper method of	f self-administration of the medic ncy of use of the medication pre	ation prescribed above
Physician's Name	Signature		Date	
Office Stamp:				

This form must be individually completed for <u>all medications</u>. Medications are to be brought to school by the parent in the **original container**, labeled appropriately by the pharmacy. All medications **will be kept** in a locked storage area.