Monmouth County Vocational School District

SELF-MEDICATION AND PHYSICIAN CERTIFICATION FOR A STUDENT WITH A LIFE-THREATENING ILLNESS / ALLERGIC REACTION

In accordance with P.L. 2007, c.57 _____ (*print name of physician*) certify that I am the physician of _____ (*print name of student*). This patient suffers from _____ (*print name of illness*), a potentially life-threatening illness / allergic reaction, and is capable of, and has been instructed in, the proper method of self-administration of medication for this illness / allergic reaction.

The student is physically fit to attend school and is free of contagious disease and would not be able to attend school if the medication is not administered during school hours.

Name of Medication _____

Dose and Route _____ **Time:** _____

Side Effects _____

Additional Instructions _____

Physician Signature / Stamp: _____ **Date:** _____

We, _____(*print names of parents*), are the parents or guardians of _____(*print name of student*), a student in the Monmouth County Vocational School District (MCVSD). As required by law, this form provides to the MCVSD Board of Education our written authorization for our child to self-administer medication for a life-threatening illness or is subject to a life-threatening illness allergic reaction. By signing this form, we release the MCVSD Boards, its employees and agents, from any liability as a result of any injury from the self-administration of medication by our child and we expressly agree to defend, protect, indemnify, and hold harmless the Monmouth County Vocational School District, and its employees or agents, from all losses, costs, suits or claims which may result from the self-administration of medication by our child. Permission to self-administer is effective upon approval and notification by the MCVSD Board of Education. Permission remains in effect only for the present school year.

SIGNATURES

Parent / Guardian _____ Date _____

School Nurse _____ Date _____

Principal _____ Date _____

School Physician _____ Date _____

American Lung Association.

My Asthma **Action Plan**
For Home and School

Name: _____ DOB: ____ / ____ / _____

Severity Classification: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Asthma Triggers (list): _____

Peak Flow Meter Personal Best: _____

Green Zone: Doing Well

Symptoms: Breathing is good – No cough or wheeze – Can work and play – Sleeps well at night
Peak Flow Meter _____ (more than 80% of personal best)

Flu Vaccine—Date received: _____ **Next flu vaccine due:** _____ **COVID19 vaccine—Date received:** _____

Control Medicine(s)	Medicine	How much to take	When and how often to take it	Take at
	_____	_____	_____	☐ Home ☐ School
	_____	_____	_____	☐ Home ☐ School

Physical Activity ☐ Use Albuterol/Levalbuterol ____ puffs, 15 minutes before activity ☐ with all activity ☐ when you feel you need it

Yellow Zone: Caution

Symptoms: Some problems breathing – Cough, wheeze, or tight chest – Problems working or playing – Wake at night
Peak Flow Meter _____ to _____ (between 50% and 79% of personal best)

Quick-relief Medicine(s) ☐ Albuterol/Levalbuterol ____ puffs, every 20 minutes for up to 4 hours as needed
Control Medicine(s) ☐ Continue Green Zone medicines
☐ Add _____ ☐ Change to _____

You should feel better within 20-60 minutes of the quick-relief treatment. If you are getting worse or are in the Yellow Zone for more than 24 hours, THEN follow the instructions in the RED ZONE and call the doctor right away!

Red Zone: Get Help Now!

Symptoms: Lots of problems breathing – Cannot work or play – Getting worse instead of better – Medicine is not helping
Peak Flow Meter _____ (less than 50% of personal best)

Take Quick-relief Medicine NOW! ☐ Albuterol/Levalbuterol ____ puffs, _____ (how frequently)

Call 911 immediately if the following danger signs are present:
- Trouble walking/talking due to shortness of breath
- Lips or fingernails are blue
- Still in the red zone after 15 minutes

School Staff: Follow the Yellow and Red Zone instructions for the quick-relief medicines according to asthma symptoms.
The only control medicines to be administered in the school are those listed in the Green Zone with a check mark next to "Take at School".

☐ Both the Healthcare Provider and the Parent/Guardian feel that the child has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

Healthcare Provider
Name _____ Date _____ Phone (____) ____ - _____ Signature _____

Parent/Guardian
☐ I give permission for the medicines listed in the action plan to be administered in school by the nurse or other school staff as appropriate.
☐ I consent to communication between the prescribing health care provider or clinic, the school nurse, the school medical advisor and school-based health clinic providers necessary for asthma management and administration of this medicine.

Name _____ Date _____ Phone (____) ____ - _____ Signature _____

School Nurse
☐ The student has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

Name _____ Date _____ Phone (____) ____ - _____ Signature _____

Please send a signed copy back to the provider listed above.

1-800-LUNGUSA | Lung.org