Asthma Ac	ction Plar		Date Completed		
Nanto		Date of Birth	Grade/Teacher		
Health Care Provider Parent/Guardian Parent/Guardian/Alternate Emergency Contact		Health Care Provider's Office Phone	Medical Record Number		
		Phone	Allernate Phone		
		Phone	Alternate Phone		
DIAGNOSIS OF ASTHWA SEVERITY		ASTHWA TRIGGERS (Things Th	nat Make Asthma Worse)		
☐ Intermittent ☐ Persistent [C	Mild Moderate Severe	☐ Smoke ☐ Colds ☐ Ex☐ Weather ☐ Odors ☐ Po	xercise		
GREEN ZONE: GO!	Take These DAILY CONTRO	LLER WEDICINES (PREVENTION) Medicines EVERY DAY		
You have ALL of these: Breathing is easy No cough or wheeze Can work and play Can sleep all night	No daily controller medicine Daily controller medicine Takepuff(s) or	☐ No daily controller medicines required ☐ Daily controller medicine(s):			
,	ALWAYS RINSE YOUR MOUTH AFTER USING YOUR DAILY INHALED MEDICINE.				
YELLOW ZONE: CAUTION!	Continue DAILY CONTROLL	ER WEDICINES and ADD QUIEK	RELEE Medicines		
You have ANY of these: • Cough or mild wheeze • Tight chest • Shortness of breath • Problems sleeping, working, or playing	Take puffs every _ Take a Other If quick-relief medicine does not go the control of the cont	hours, <i>if needed.</i> Always uso			
RED ZONE: EWERGENCY!	Continue DAILY CONTROL	LER WEDICINES and QUICK-RELI	JEF Medicines and 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 fingernalls are grey or bluish	Take a Take a Other CALL HEALTH CARE PROVIDING be contacted, CALL 911 FOR	nebuliza	inhalermcg e a spacer, some children may need a mask,nebulizermg /ml er trealment everyhours, if needed. LIEF MEDICINE. If health care provider cannot TO THE EWERGENCY DEPARTMENT!		
	ALL MEDICATION USE AT SCHOO	L			
Signature			Date		
DEM K YEXUX MEDUZENEM XONOGMEX NEMS	KWXWXXXWWXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	(84 X6KO 6X5K KIXSKOH XII)K MUKUKIXISK XIDOK _ Date		
	NDEPENDENT MEDICATION CAR				
Health Care Provider Independent Car		s student has demonstrated to me that t	hey can self-administer this rescue medication Date		
Parent/Guardian Independent Carry a may carry and use this medication inde	pendently at school with no supervision	i by school personnel.	Iminister this rescue medication effectively and		
Signature	makipu di nagajan di nagagan di nagi ya ya yaidi ngisan gani ga danasa ga ya ya ana apsanya sani iya gisanasa sa sa	ate Department of Health	5/1		

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 request that my child be pursuant to N.J.S.A. 18A:40-12 prescribed on this form for the storing and self-administrating no liability as a result of any coprescribed on this form. I inder	2.3 and 12.4. I give permission current school year. I consider the medication. I understand the modition or injury arising from the	administer in school, his asthm for my child to self-administer his, him/her to be responsible and ca at the school district, agents and a self-administration by the stude thool District, its agents and emplo	/her medication, as pable of transporting, its employees shall incurnt of the medication
taking the medication describe medication to students in scho of the medication is mine, and at another location at the time employees shall incur no liabili administration of the medicatio	ed below at school by the School of pursuant to N.J.A.C:.6A:16-2 I am fully aware that the duties that the medication is needed. Ity as a result of any condition on prescribed on this form. I independent	ma medication. I request that m I Nurse or other individuals author.3. I understand the ultimate responded the school nurse and others munderstand that the school distriction in the administration and hold harmless the School distriction of this medical ack of administration of this medical services.	orized to administer ponsibility for administration hay require their presence ct, agents and its ation or lack of hool District, its agents and
Parent/Guardian Signature	Telephone	 Date	
II. Healthcare Provider C	Order:		
Name of medication:	· · · · · · · · · · · · · · · · · · ·	,	
Dosage:	Route:	Frequency:	
For Student Self Administration:This student has been instructedThis student understands theThis student is not approved	e purpose, appropriate method an	ethod of self-administration of the medication	edication 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.