# ASTHMA ACTION PLAN

Asthma and Allergy Foundation of America
aafa.org

| | |
|---|---|
| Name: | Date: |
| Doctor: | Medical Record #: |
| Doctor's Phone #: Day | Night/Weekend |
| Emergency Contact: | |
| Doctor's Signature: | |

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

**GREEN means Go Zone!**
Use preventive medicine.

**YELLOW means Caution Zone!**
Add quick-relief medicine.

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

## Personal Best Peak Flow: _____

### GO — Use these daily controller medicines:

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

**Peak flow:**
from _____
to _____

| MEDICINE | HOW MUCH | HOW OFTEN/WHEN |
|---|---|---|
| | | |
| | | |
| | | |

For asthma with exercise, take:

| | | |
|---|---|---|
| | | |

### CAUTION — Continue with green zone medicine and add:

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

**Peak flow:**
from _____
to _____

| MEDICINE | HOW MUCH | HOW OFTEN/ WHEN |
|---|---|---|
| | | |
| | | |
| | | |

CALL YOUR ASTHMA CARE PROVIDER.

### DANGER — Take these medicines and call your doctor now.

**Your asthma is getting worse fast:**
- Medicine is not helping
- Breathing is hard & fast
- Nose opens wide
- Trouble speaking
- Ribs show (in children)

**Peak flow:**
reading below _____

| MEDICINE | HOW MUCH | HOW OFTEN/WHEN |
|---|---|---|
| | | |
| | | |
| | | |

**GET HELP FROM A DOCTOR NOW! Your doctor will want to see you right away. It's important!**
**If you cannot contact your doctor, go directly to the emergency room. DO NOT WAIT.**
Make an appointment with your asthma care provider within two days of an ER visit or hospitalization.

American Lung Association.

# How to Use a Metered-Dose Inhaler with a Valved Holding Chamber (Spacer)

**Prime a brand-new inhaler:** Before using it for the first time, if you have not used it for more than 7 days, or if it has been dropped.

1. Shake inhaler 10 seconds.

2. Take the cap off the inhaler and valved holding chamber. Make sure the mouthpiece and valved holding chamber are clean and there is nothing inside the mouthpieces.

3. Put inhaler into the chamber/spacer.

4. Breathe out away from the device.

5. Put chamber mouthpiece in mouth.

6. Press inhaler once and breathe in deep and steadily.

7. Hold your breath for 10 seconds, then breathe out slowly.

   If you need another puff of medicine, wait 1 minute and repeat steps 4-7.

8. Rinse with water and spit it out.

Proper inhalation technique is important when taking your asthma medicine(s) and monitoring your breathing. Make sure to bring all your medicines and devices to each visit with your primary care provider or pharmacist to check for correct use, or if you have trouble using them.

For more videos, handouts, tutorials and resources, visit Lung.org.

Scan the QR Code to access How-To Videos

You can also connect with a respiratory therapist for one-on-one, free support from the American Lung Association's Lung HelpLine at **1-800-LUNGUSA**.

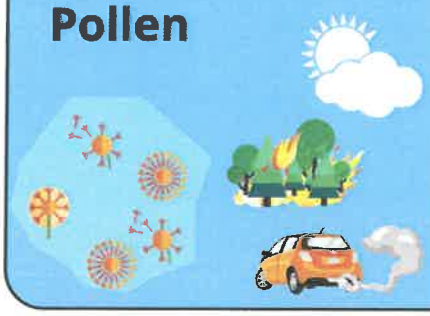
# Know Your Asthma Triggers.

**Learn how to avoid triggers to control your asthma.**

Triggers are things that make your asthma symptoms worse. People with asthma do not all have the same triggers. Avoiding your triggers is one step you can take to help keep your asthma under control. Work with your healthcare provider to check whether any of these things make your asthma worse, then take the related steps below. Check CDC's webpage for other steps you can take: **www.cdc.gov/asthma**

## Outdoor Triggers

### Weather
### Air Quality
### Pollen



- Pay attention to radio, television, the internet, or newspaper reports about things that might trigger your asthma. These might include reports about weather, air quality, pollen count, or wildfire conditions.
- Plan outdoor activities for when the air quality is best.
- If pollen triggers your asthma, close windows and turn on air conditioning (if possible) when pollen levels are high.
- When there are wildfires, stay away from areas where there is smoke or vapors. Stay indoors, if possible, to avoid smoke or vapors.
- When it is cold, wear a scarf or face mask that covers your nose and mouth to keep airflow as warm as possible.

## Indoor Triggers

If you are allergic to dust mites, cockroaches, rodents, indoor mold, or pets, use an air purifier with a high-energy particulate air (HEPA) filter, and use HEPA filters for vacuum cleaners. Keep your home as clean as possible. If you can, ask someone else to clean your home regularly, or wear a dust mask while you clean.

### Pets

If you are allergic to your pet, the best way to avoid exposure is to remove the pet from your home and have the house cleaned. If you can't remove the pet:

- Keep the pet out of your bedroom.
- Ask a family member to wash your pet regularly.
- Use allergen-proof pillow and mattress covers.
- Use an air cleaner with HEPA filter.

Note: Pet fur, skin, and saliva trigger some people's asthma.

### Dust mites

(tiny bugs that live in dust and fabric)

- Keep relative humidity levels in your home low, around 30%–50%.
- Wash your bedding every week and dry completely.
- Use allergen-proof pillow and mattress covers.

# Know Your Asthma Triggers.

## Indoor Triggers

| | |
|---|---|
| **Cockroaches**<br>**Mice**<br>**Rats**<br>  | • Keep your kitchen clean and store food and garbage in closed containers.<br>• Don't leave out any standing water or other liquids.<br>• Seal cracks or openings in cabinets, walls, floorboards, and around plumbing.<br>• Use traps or poison bait to get rid of roaches, mice, or rats. Keep bait away and out of reach of children and pets. Avoid sprays and foggers. |
| **Mold**<br>**Humidity**<br>  | • Fix water leaks as soon as possible and dry damp or wet items within 48 hours.<br>• Remove all moldy items from your home.<br>• Use an air conditioner or dehumidifier to keep the air dry in your home. Keep relative humidity levels in your home low, around 30%–50%.<br>• Empty and clean refrigerator and air conditioner drip pans regularly.<br>• Use bathroom exhaust fans or open windows when you shower. |
| **Smoke**<br>**Sprays**<br>**Scents**<br>**Disinfectants**<br>  | • Avoid places where people smoke. If you smoke, ask your healthcare provider how to quit.<br>• Don't use a wood-burning stove, kerosene heater, or fireplace.<br>• Avoid perfume, paint, hairspray, and talcum powder.<br>• Try to stay away when cleaners or disinfectants are being used and right after their use.<br>• Increase air flow by opening doors and windows and turning on exhaust fans. |

## Other Common Triggers

| | |
|---|---|
| **Illness**<br>  | • Contact your healthcare provider if you think you have another health problem that is making it harder for you to breathe. Such problems might include the flu, a cold, acid reflux (heartburn), a sinus infection, severe allergies, or another health concern. |
| **Emotions**<br>  | • Talk to your healthcare provider if anxiety, stress, or other emotions make your asthma worse. |

**Notes:**

ARROWACADEMY
MARKED WITH PURPOSE

# Asthma History Form

School year:_____

**Student**:_____ Grade:_____ Date of Birth:_____

Physician:_____ Phone number:_____

**A.History**

1. How old was your child when diagnosed with asthma?

2. Describe the symptoms your child has with a typical asthma episode (wheeze, cough, shortness of breath, etc.)

3. How does your child describe these symptoms?

4. How frequently does your child experience each type of symptom?

| | Times/Week | Times/Month | Times/Year | Never |
|---|---|---|---|---|
| **Mild** (resolves quickly with rest or medication) | _____ | _____ | _____ | _____ |
| **Moderate** (requires a doctor visit to get things under control) | _____ | _____ | _____ | _____ |
| **Severe** (requires a visit to the Emergency Room) | _____ | _____ | _____ | _____ |

5. Has your child ever been hospitalized for asthma? _____ No _____ Yes
   If yes, please explain:

6. Identify the things that may trigger your child to have an asthma episode. Check all that apply.

- ☐ Exercise
- ☐ respiratory infections
- ☐ cold temperature
- ☐ hot temperatures
- ☐ change in temperature
- ☐ strong odors/fumes
- ☐ chalk dust
- ☐ sitting on a carpet
- ☐ pollen
- ☐ mold
- ☐ Animals
- ☐ Dust
- ☐ foods
- ☐ Ozone alert days
- ☐ Other _____

Comments:

**B.Current Asthma Management**

7. How does your child understand his/her asthma and what he/she should do to manage it?

8. Please list the medications your child takes routinely, the dosage, how often taken, when and under what circumstances additional doses may be given.

| Medication | Dosage | How Often | Additional Doses |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

9. Does your child suffer side effects from the medication? _____ No _____ Yes
If yes, please list medication and specific side effects.

| Medication | Side Effects |
|---|---|
| | |
| | |
| | |

**SCHOOL ASTHMA ACTION PLAN/ASTHMA MEDICATIONS**

*Students with asthma must submit this Asthma-Student Health History (completed), an Asthma Treatment Plan (completed and signed by the student's doctor and signed by the parent on both sides), and the prescribed medication to the school nurse.*

*The district is required to keep an Asthma Action Plan on file for all students who require an asthma inhaler or nebulized medication here at school.*

*An Asthma Action Plan includes information about medications & asthma triggers, which is important information for proper asthma management at both home and school.*

*All medications must be brought in by a parent and kept in the health office unless approval has been given by the health office and the student's physician for a student to self-carry an inhaler. If your child has permission to self-carry an inhaler, please send an extra one to be kept in the health office in the event your child forgets to bring it to school.*

*All medication forms (including asthma and allergy forms) are required to be updated and resubmitted each school year at the beginning of the year. Failure to do so may compromise our ability to safely care for your child.*

*If you have any questions, please contact the school nurse- Susan Peluso RN at susan@thearrowacademy.org*

Parent/Guardian signature:_____ Date:_____

# 2024-2025 MANDATORY MEDICATION FORM

**ALL MEDICATION (prescription and OTC, including Tylenol and Advil) must be accompanied by written permission from BOTH the PARENT and PHYSICIAN.**

- **Prescription medication** must be delivered to the nurse by the parent in the original container, labeled with the student's name, medication, dosage and physician's name.
- **OTC medication** must be delivered to school by the parent in the original sealed container and labeled with the student's name.
- **Written permission** of the student's physician and parent/guardian are required, including the student's name, purpose of the medication, the time (or circumstance) at which the medication should be administered, and the length of time for which the medication is prescribed.

Only those medications which are medically necessary during school hours for a student's wellbeing should be sent to school.

**NOTE: THE FIRST DOSE OF ANY MEDICATION MAY *NOT* BE GIVEN AT SCHOOL.**

NAME OF STUDENT _____ DOB _____

NAME OF MEDICATION _____

DOSAGE _____

TIME TO BE GIVEN _____

REASON FOR MEDICATION _____

MEDICATION TO BE GIVEN FROM _____ (DATE) TO _____ (DATE)

HOW IT IS TAKEN _____
EXAMPLE: BY MOUTH, INHALER, WITH FOOD, CRUSHED, ETC.

ADDITIONAL COMMENTS _____

_____ PARENT SIGNATURE/DATE

_____ TELEPHONE NUMBER

_____ PHYSICIAN SIGNATURE/DATE

_____ TELEPHONE NUMBER

# ADDITIONAL MEDICATIONS

NAME OF STUDENT _____ DOB _____

NAME OF MEDICATION _____

DOSAGE _____

TIME TO BE GIVEN _____

REASON FOR MEDICATION _____

MEDICATION TO BE GIVEN FROM _____ TO _____
DATE DATE

HOW IT IS TAKEN _____
EXAMPLE: BY MOUTH, INHALER, WITH FOOD, CRUSHED, ETC.

ADDITIONAL COMMENTS _____

NAME OF STUDENT _____ DOB _____

NAME OF MEDICATION _____

DOSAGE _____

TIME TO BE GIVEN _____

REASON FOR MEDICATION _____

MEDICATION TO BE GIVEN FROM _____ TO _____
DATE DATE

HOW IT IS TAKEN _____
EXAMPLE: BY MOUTH, INHALER, WITH FOOD, CRUSHED, ETC.

ADDITIONAL COMMENTS _____

**********

_____ _____
PARENT SIGNATURE/DATE PHYSICIAN SIGNATURE/DATE

_____ _____
TELEPHONE NUMBER TELEPHONE NUMBER

**2024-2025 PHYSICIAN/PARENT CERTIFICATION FOR STUDENT'S SELF-ADMINISTRATION OF MEDICATION**

**CERTIFICATION TO BE COMPLETED BY PHYSICIAN**

STUDENT NAME: _____

DIAGNOSIS: _____

NAME OF MEDICATION: _____

DOSAGE: _____

TIME AND CIRCUMSTANCES OF ADMINISTRATION: _____

POSSIBLE SIDE EFFECTS: _____

I certify that _____ has a potentially life threatening illness
(Student)
which requires the use of _____. I further certify that
(Medication)
_____ is capable and has been instructed in the proper method of
(Student)
self-administration of _____
(Medication)

_____ _____
Signature of Physician Date

PHYSICIAN NAME: _____ TELEPHONE #: _____

**********

**CERTIFICATION TO BE COMPLETED BY PARENT**

I hereby authorize my son/daughter _____ to self-administer (Name of Medication) _____ in accordance with special guidelines.

I acknowledge that the school shall incur no liability as a result of any injury arising from the self-administration of medication by (student name) _____.

I shall indemnify and hold harmless the school, its employees and agents against any and all claims arising out of the self-administration of (medication) _____ by (student name) _____.

_____ _____
Parent/Guardian Signature Date

**SELF-ADMINISTRATION OF MEDICATION IN SCHOOL**

Under N.J.S.A. 18A:40-12.3, self-administration of medication by a pupil for asthma or other potentially life threatening illness is allowed under guidelines established by the school and provided that the statutory requirements set forth in this form are complied with.

Any permission for the self-administration of medication is effective for this school year only.

N.J.S.A. 18A:40-12.3 PROVIDES THAT THE SCHOOL SHALL INCUR NO LIABILITY AS A RESULT OF ANY INJURY ARISING FROM THE SELF-ADMINISTRATION OF MEDICATION BY A STUDENT.

**Rev: 4/2015**

# PERMISSION TO SHARE INFORMATION
# 2024-2025

As you are aware, everyday each of our students has contact with a variety of staff members; teachers, bus drivers, therapists, assistants, cafeteria workers, and student interns. While your child is in the care of these people, it is important that they are aware of any information that would require special considerations for his or her health and safety.

To comply with privacy laws, I am requesting your permission to share personal information about your child. This would consist of only that information deemed necessary to protect the well-being of your child. Examples of information that could be shared about your child may include; known allergies, special diets or food restriction, and a history of seizures. This may be done in the form of a printed list or verbal contact with those people who will be working closely with your child. If you have specific questions regarding your child, please call me at school. As always, please feel comfortable knowing that any information you do not want shared with anyone will be kept confidential. Thank you.

**PLEASE COMPLETE, SIGN BELOW AND RETURN THIS FORM TO YOUR CHILD'S SCHOOL**

**Child's Name:** _____

_____ **Yes,** I give permission for personal information about my child to be shared with other staff members if it will protect his/her health and safety.

_____ **No,** I do not give permission for personal information about my child to be shared with other staff members if it will protect his/her health and safety.

_____ _____

Parent/Guardian Signature Date

ARROWACADEMY
MARKED WITH PURPOSE
Health Office
90 Whippany Rd, Whippany, NJ, 07981
(973) 888-2083

# MEDICATION PROTOCOL

Medication will be given in school only when a pupil's health and continuing attendance in school requires it and it is administered in accordance with the medication policy. **No student is to carry medication** to and from school. If it is necessary that medication be taken during school hours, the following is required:

1. All medication, prescription and over the counter, must be accompanied by a written request from a physician. These orders must include the diagnosis or type of illness, name of drug, dosage, time of administration, length of time for which it is required, and side effects of medication. Written orders must be renewed on an annual basis at the beginning of each school year.
2. A Mandatory Medication Form, Asthma Action Plan and/or Allergy Emergency Treatment form must be completed by the primary care provider and signed by parent/guardian.
3. Medication is to be in the correct prescription bottle, labeled with the name of the child, current dosage, date of prescription, and name of prescribing primary care provider
4. Parents must bring all medications to the Health Office. Students should never carry medication to school unless the doctor specifically orders that the student may carry and self-administer emergency epinephrine or inhaler.
5. Self-administration of medication for asthma or other potentially life-threatening illnesses require additional doctor and parent signatures on the form.
6. Non Prescription medications (i.e. Ibuprofen, Tylenol) may only be administered when a Mandatory Medication Form is completed by the primary care provider and signed by a parent. These medications must come in the original container.
7. According to NJ Law, school nurses cannot administer alternative remedies such as herbal medications and essential oils.
8. No parent's or primary care provider's phone instructions can be accepted.
9. Parents must pick up the medication from the Nurse in June on the last day of school. No medications will be sent home with a student. Medications will be properly disposed of if parents do not pick up the medication on the last day of school.

ARROWACADEMY
MARKED WITH PURPOSE
Health Office
90 Whippany Road
43 South Jefferson Road
Whippany, NJ
(973) 888-2083

# Medication Permission Form

School Year_____

Student's Name: _____ DOB: _____

Name of Medication: _____

Dosage:_____ Route Given:_____

Time To Be Given:_____

Reason For Medication:_____

Medication To Be Given From _____ To_____
DATE DATE

Physician's Name:_____ Phone: _____

Additional Comments: _____

_____

I,_____, give permission for The Arrow Academy Staff to administer the above medication to my child, _____.

*Parent/Guardian Name (Print): _____

*Parent/Guardian Signature:_____ Date:_____

** Valid prescription must accompany this form

Revised 5/24