Middle Township Middle School

300 East Pacific Avenue
Cape May Court House, New Jersey
08210-9936 Telephone (609) 465-1834
FAX (609) 465-5524
middletownshippublicschools.org

Mr. J. Ortman
Principal

Mr. A. Hodges
Asst. Principal

Date: ___________________________

To the Parent or Guardian of: ____

The Middle Township School District must have a health plan in place for children with a health concern. The health care plan helps to ensure a better understanding of your child's healthcare needs, and is reviewed with your child's teachers and principal. Please take the enclosed Asthma Action Plan and medication permission form to your child's doctor for his approval and signature; also the parent/ guardian needs to sign the forms and bring the medication to school.

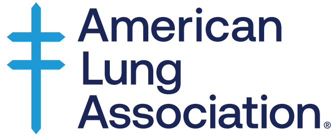
If the Action Plan is not returned to the school nurse and the school nurse has not received a phone call from you regarding this matter, I will conclude that the medical condition has been resolved and is no longer a problem which must be addressed by the school nurse.

Please contact me if you have any questions. I can be reached at 609-465-1834 ext. 4006.

Sincerely,

LeeAnn Kane, R.N.

"An Equal Opportunity Employer"



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

Middle Township Middle School
300 East Pacific Avenue
Cape May Court House, NJ 08210

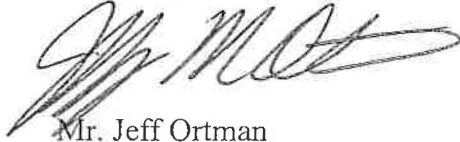
Dear Parent/Guardian,

On December 23, 1993 State Law I-2000 went into effect. This law allows parents/guardian to grant written permission for their children to self administer medication for asthma or other potentially life threatening illnesses.

Please complete the form below and have your child return it to the school nurse. If you decide to allow your child to "self administer" his/her medication, you must produce a physician's note certifying that the student is capable of, and has been instructed in the proper administration of the required drug.

Thank you for your attention in this matter.

Sincerely,



Mr. Jeff Ortman
Principal

PLEASE CHECK OFF YOUR DECISION, SIGN THE LETTER AND SEND IT TO SCHOOL WITH YOUR CHILD.

☐ Yes, my child may "Self Administer" medication in school and on field trips. Attached is the physician's note certifying that my child is capable of and has been instructed in proper administration of the required drug. **I understand the district shall incur no liability as a result of any injury arising from the self medication, and I hold the district harmless against any injury or claims that arise as a result of my child's self administration.**

☐ **No, my child MAY NOT self administer medication.**

____

Signature of Parent/Guardian

____

Child's Name **Date** **Grade**