Asthma Treatment Plan — Student (This asthma action plan meets NJ Law N.J.S.A. 18A:40-12.8) (Physician's Orders)







(Please Pr	int)				
Name			Date of Birth	Effective Date	
Doctor		Parent/Guardian (if ap	pplicable)	Emergency Contact	
Phone		Phone	Phone Phone		
HEALTHY	(Green Zone) III	Take daily control more effective with	nedicine(s). Some a "spacer" – use i	inhalers may be f directed.	Triggers Check all items
	You have <u>all</u> of these:	MEDICINE		d HOW OFTEN to take it	that trigger patient's asthma:
9 (20)	Breathing is goodNo cough or wheeze	Advair® HFA 45, 115,	2302 puffs tv	vice a day	☐ Colds/flu
	• Sleep through	☐ Aerospan™ ☐ Alvesco® ☐ 80, ☐ 160 ☐		2 puffs twice a day 2 puffs twice a day	☐ Exercise
R. M.	the night	☐ Dulera® ☐ 100, ☐ 200	2 puffs tv	vice a day	☐ Allergens
A PAR	• Can work, exercise,	☐ Dulera® ☐ 100, ☐ 200 ☐ Flovent® ☐ 44, ☐ 110, ☐ 220	2 puffs tv	vice a day	Dust Mites, dust, stuffed
Ma	and play	☐ Qvar® ☐ 40, ☐ 80 ☐ Symbicort® ☐ 80, ☐ 160 ☐ Advair Diskus® ☐ 100, ☐ 250,		puffs twice a day	animals, carpet
		☐ Advair Diskus® ☐ 100, ☐ 250,	5001 inhalati	on twice a day	O Pollen - trees, grass, weeds
		∐ Asmanex® Iwistnaler® ∐ 110, [220	inhalations 🔲 once or 🔲 twice a day	o Mold
		☐ Flovent® Diskus® ☐ 50 ☐ 100 ☐ Pulmicort Flexhaler® ☐ 90, ☐	☐ 2501 inhalati	on twice a day inhalations □ once or □ twice a day	O Pets - animal
		Pulmicort Respules® (Budesonide)] 0.25,	oulized 🗌 once or 🔲 twice a day	dander • Pests - rodents
		☐ Singulair® (Montelukast) ☐ 4, ☐	5, 🗌 10 mg1 tablet d	aily	cockroaches
And/or Dool	flow above	☐ Other☐ None			Odors (Irritants)
Anu/or Fear	THOW above		or to rince your mouth a	fter taking inheled medicine	_ ○ Cigarette smok & second hand
the exercises triggers your notine toke					
			pan(s)_		Perfumes, cleaning
GAUTION	(Yellow Zone) IIII	Continue daily control n	nedicine(s) and ADD q	uick-relief medicine(s).	products, scented
	You have <u>any</u> of these: • Cough	MEDICINE	HOW MUCH to take an	d HOW OFTEN to take it	products Smoke from
()	Mild wheeze	☐ Albuterol MDI (Pro-air® or Prov	ventil [®] or Ventolin [®]) _2 puffs	s every 4 hours as needed	burning wood,
	• Tight chest	☐ Xopenex®			inside or outsid
	Coughing at night	☐ Albuterol ☐ 1.25, ☐ 2.5 mg _	1 unit i	nebulized every 4 hours as needed	o Sudden
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	• Other:	☐ Duoneb®	1 unit :	nebulized every 4 hours as needed	temperature change
		☐ Xopenex® (Levalbuterol) ☐ 0.31,			Extreme weath
	nedicine does not help within	Combivent Respimat® Increase the dose of, or add:	I Innai	ation 4 times a day	- hot and cold
	or has been used more than	Other			<ul> <li>Ozone alert day</li> <li>☐ Foods:</li> </ul>
2 timos and symptoms persist, can your			cine is needed mo	re than 2 times a	O
And/or Peak flow from to week, except before					0
					<u> </u>
EMERGENCY (Red Zone)    Take these medicines NOW and CALL 911.					
Series Control	Your asthma is	Asthma can be a li	fe-threatening illn	ess. Do not wait!	0
25.	getting worse fast: • Quick-relief medicine did	MEDICINE		take and HOW OFTEN to take i	t o
	not help within 15-20 minut				
(Mary)	Breathing is hard or fast     Naga appropriate a Piles about	☐ Xopenex®		4 puffs every 20 minutes 1 unit nebulized every 20 minutes	This asthma treatmer
	<ul> <li>Nose opens wide • Ribs she</li> <li>Trouble walking and talking</li> </ul>	a   🗀 Duoneb®		1 unit nebulized every 20 minutes	plan is meant to assis
And/or	• Lips blue • Fingernails blue	e ☐ Xopenex® (Levalbuterol) ☐ 0.	.31, 🗌 0.63, 🔲 1.25 mg	1 unit nebulized every 20 minutes	decision-making
Peak flow	Other:			1 inhalation 4 times a day	required to meet
below		Other			individual patient nee
Disclaimers: Pressy differ files (1994) profite to it its of total. The American to traditional than Array and all of place decision to the contest array and all of place decision	N Asian Teamor Ne, and as subsets a your words. The covered is not decreased at the Middle for IAAN A) the Research of Johns not controlled against the Middle Asia again allowed to the controlled and the Middle Asia and	ssion to Self-administer Medication	DUVOIOIAN/ADN/DA OICE/AT	LIDE	DATE
Figure 1976 in the second of the contraction of the	r announce of the report of signs, continued to the continued of the continued to the conti	student is capable and has been instructed		UREPhysician's Orders	DATE
於 的反於 所謂 40 以 200 本國或 6 107 對 44.	otolina Aurini Transcri Procedim post on words, conso, articl 4 s abord difespositi in it such denga. Al Ald Alad in affato act	e proper method of self-administering of th	ne	•	
in Rath for the film, whichever carried by an its Problem Wed waters Condition of New York was recognized for a ground in white New York Day	no state of course of the Administratives (Plan, lest of the western).  In controlled the Marketon Long Execution's Librariously, littles publication  The Controlled Librarious Conference and Marketon Librariously, littles publication.	nebulized inhaled medications named abovecordance with NJ Law.	/e   PAKENT/GUARDIAN SIGNAT	URE	

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Make a copy for parent and for physician file, send original to school nurse or child care provider.

 $\hfill\Box$  This student is  $\underline{not}$  approved to self-medicate.

PHYSICIAN STAMP

## Asthma Treatment Plan – Student Parent Instructions

The **PACNJ Asthma Treatment Plan** is designed to help everyone understand the steps necessary for the individual student to achieve the goal of controlled asthma.

- 1. Parents/Guardians: Before taking this form to your Health Care Provider, complete the top left section with:
  - Child's name
- Child's doctor's name & phone number

• Parent/Guardian's name

- · Child's date of birth
- An Emergency Contact person's name & phone number
- & phone number

- 2. Your Health Care Provider will complete the following areas:
  - The effective date of this plan
  - The medicine information for the Healthy, Caution and Emergency sections
  - Your Health Care Provider will check the box next to the medication and check how much and how often to take it
  - Your Health Care Provider may check "OTHER" and:
    - Write in asthma medications not listed on the form
    - Write in additional medications that will control your asthma
    - * Write in generic medications in place of the name brand on the form
  - Together you and your Health Care Provider will decide what asthma treatment is best for your child to follow
- 3. Parents/Guardians & Health Care Providers together will discuss and then complete the following areas:
  - Child's peak flow range in the Healthy, Caution and Emergency sections on the left side of the form
  - Child's asthma triggers on the right side of the form
  - <u>Permission to Self-administer Medication</u> section at the bottom of the form: Discuss your child's ability to self-administer the inhaled medications, check the appropriate box, and then both you and your Health Care Provider must sign and date the form
- **4. Parents/Guardians:** After completing the form with your Health Care Provider:
  - Make copies of the Asthma Treatment Plan and give the signed original to your child's school nurse or child care provider
  - Keep a copy easily available at home to help manage your child's asthma
  - Give copies of the Asthma Treatment Plan to everyone who provides care for your child, for example: babysitters, before/after school program staff, coaches, scout leaders

PARENT AUTHORIZATION I hereby give permission for my child to receive medication at school as prescribed in the Asthma Treatment Plan. Medication must be provided in its original prescription container properly labeled by a pharmacist or physician. I also give permission for the release and exchange of information between the school nurse and my child's health care provider concerning my child's health and medications. In addition, I understand that this information will be shared with school staff on a need to know basis.					
Parent/Guardian Signature	Phone	Date			
FILL OUT THE SECTION BELOW ONLY IF YOUR HEALTH CARE PROVIDER CHECKED PERMISSION FOR YOUR CHILD TO SELF-ADMINISTER ASTHMA MEDICATION ON THE FRONT OF THIS FORM.  RECOMMENDATIONS ARE EFFECTIVE FOR ONE (1) SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY					
I do request that my child be <b>ALLOWED</b> to carry the following medication for self-administration in school pursuant to N.J.A.C:.6A:16-2.3. I give permission for my child to self-administer medication, as prescribed in this Asthma Treatment Plan for the current school year as I consider him/her to be responsible and capable of transporting, storing and self-administration of the medication. Medication must be kept in its original prescription container. I understand that the school district, agents and its employees shall incur no liability as a result of any condition or injury arising from the self-administration by the student of the medication prescribed on this form. I indemnify and hold harmless the School District, its agents and employees against any claims arising out of self-administration or lack of administration of this medication by the student.					
☐ I DO NOT request that my child self-administer his/her asthma medication.					
D					
Parent/Guardian Signature	Phone	Date			



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