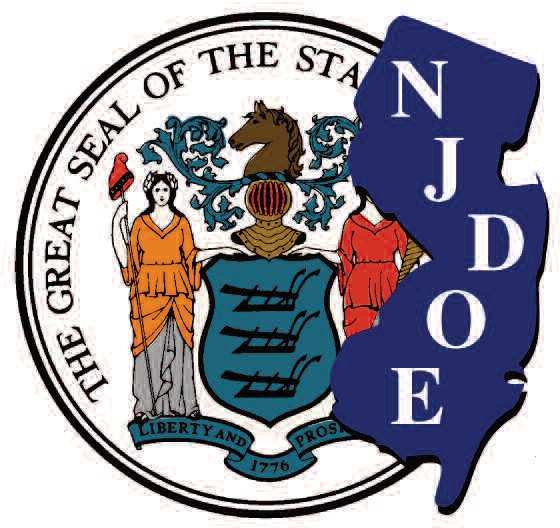
Asthma Treatment Plan – Student



*Sponsored by*

(This asthma action plan meets NJ Law N.J.S.A. 18A:40-12.8) **(Physician’s Orders)**

**(Please Print)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name | | Date of Birth | | Effective Date |
| Doctor  Phone | Parent/Guardian (if applicable)  Phone | | Emergency Contact  Phone | |

**HEALTHY (Green Zone)** ➠

**MEDICINE**

**Take daily control medicine(s). Some inhalers may be more effective with a “spacer” – use if directed.**

**You have *all* of these:**

* Breathing is good
* No cough or wheeze
* Sleep through the night
* Can work, exercise, and play

And/or Peak flow above

**HOW MUCH to take and HOW OFTEN to take it**

***Remember to rinse your mouth after taking inhaled medicine.***

* Advair® HFA □ 45, □ 115, □ 230 2 puffs twice a day
* AerospanTM □ 1, □ 2 puffs twice a day
* Alvesco® □ 80, □ 160 □ 1, □ 2 puffs twice a day
* Dulera® □ 100, □ 200 2 puffs twice a day
* Flovent® □ 44, □ 110, □ 220 2 puffs twice a day
* Qvar® □ 40, □ 80 □ 1, □ 2 puffs twice a day
* Symbicort® □ 80, □ 160 □ 1, □ 2 puffs twice a day
* Advair Diskus® □ 100, □ 250, □ 500 1 inhalation twice a day
* Asmanex® Twisthaler® □ 110, □ 220 □ 1, □ 2 inhalations □ once or □ twice a day
* Flovent® Diskus® □ 50 □ 100 □ 250 1 inhalation twice a day
* Pulmicort Flexhaler® □ 90, □ 180 □ 1, □ 2 inhalations □ once or □ twice a day
* Pulmicort Respules® (Budesonide) □ 0.25, □ 0.5, □ 1.0 1 unit nebulized □ once or □ twice a day
* Singulair® (Montelukast) □ 4, □ 5, □ 10 mg 1 tablet daily
* Other
* None

**Triggers**

**Check all items that trigger patient’s asthma:**

* Colds/flu
* Exercise
* Allergens
  + Dust Mites, dust, stuffed animals, carpet
  + Pollen - trees, grass, weeds
  + Mold
  + Pets - animal dander
  + Pests - rodents, cockroaches
* Odors (Irritants)
  + Cigarette smoke & second hand smoke

**If exercise triggers your asthma, take puff(s) minutes before exercise.**



**You have *any* of these:**

* Cough
* Mild wheeze
* Tight chest
* Coughing at night
* Other:

If quick-relief medicine does not help within 15-20 minutes or has been used more than 2 times and symptoms persist, call your doctor or go to the emergency room.

**EMERGENCY (Red Zone)** ➠

And/or Peak flow from to

**Your asthma is**

* Albuterol MDI (Pro-air® or Proventil® or Ventolin®) \_2 puffs every 4 hours as needed
* Xopenex® 2 puffs every 4 hours as needed
* Albuterol □ 1.25, □ 2.5 mg 1 unit nebulized every 4 hours as needed
* Duoneb® 1 unit nebulized every 4 hours as needed
* Xopenex® (Levalbuterol) □ 0.31, □ 0.63, □ 1.25 mg \_1 unit nebulized every 4 hours as needed
* Combivent Respimat® 1 inhalation 4 times a day
* Increase the dose of, or add:
* Other
* **If quick-relief medicine is needed more than 2 times a week, except before exercise, then call your doctor.**

**HOW MUCH to take and HOW OFTEN to take it**

**MEDICINE**

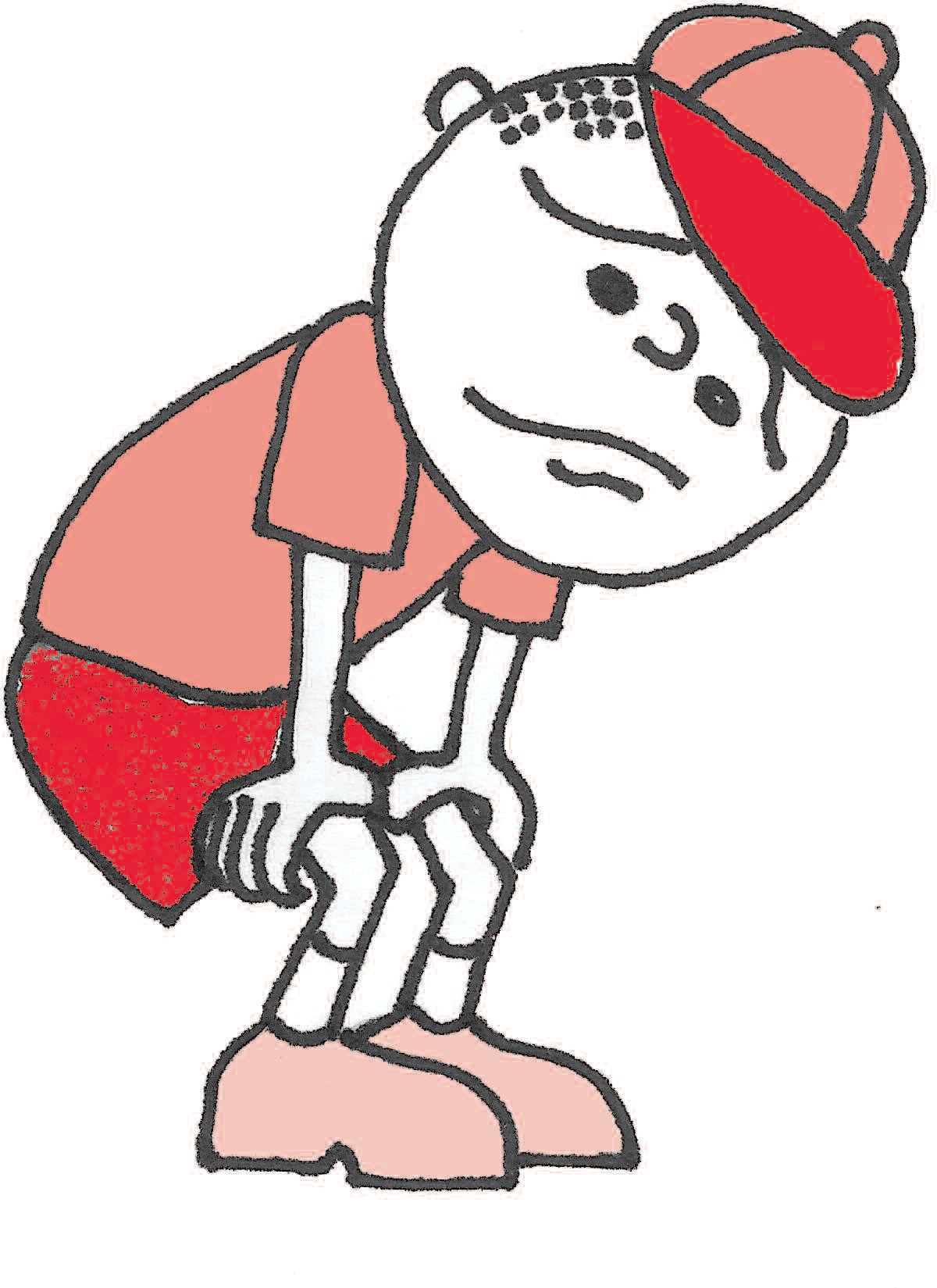
**Continue daily control medicine(s) and ADD quick-relief medicine(s).**

**Take these medicines NOW and CALL 911.**

***Asthma can be a life-threatening illness. Do not wait!***

**MEDICINE HOW MUCH to take and HOW OFTEN to take it**

* Albuterol MDI (Pro-air® or Proventil® or Ventolin®) \_ 4 puffs every 20 minutes
* Xopenex® 4 puffs every 20 minutes
* Albuterol □ 1.25, □ 2.5 mg 1 unit nebulized every 20 minutes
* Duoneb® 1 unit nebulized every 20 minutes
* Xopenex® (Levalbuterol) □ 0.31, □ 0.63, □ 1.25 mg 1 unit nebulized every 20 minutes
* Combivent Respimat® 1 inhalation 4 times a day
* Other

**getting worse fast:**

* + - Quick-relief medicine did

not help within 15-20 minutes

* + - Breathing is hard or fast
    - Nose opens wide • Ribs show
    - Trouble walking and talking
  + Perfumes, cleaning products, scented products
  + Smoke from burning wood, inside or outside
* Weather
  + Sudden temperature change
  + Extreme weather

- hot and cold

* + Ozone alert days
* Foods:


* Other:

This asthma treatment plan is meant to assist, not replace, the clinical

And/or Peak flow

* + Lips blue • Fingernails blue
  + Other:

decision-making required to meet

below

individual patient needs.

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**Permission to Self-administer Medication:**

* This student is capable and has been instructed in the proper method of self-administering of the non-nebulized inhaled medications named above in accordance with NJ Law.
* This student is not approved to self-medicate.

PHYSICIAN/APN/PA SIGNATURE DATE

Physician’s Orders

PARENT/GUARDIAN SIGNATURE

PHYSICIAN STAMP

REVISED AUGUST 2014

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

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:**

# v Write in asthma medications not listed on the form

v **Write in additional medications that will control your asthma**

v **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
    1. **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
       - Permission to Self-administer Medication 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
    2. **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.

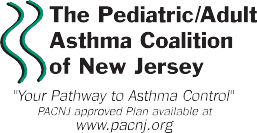
Parent/Guardian Signature Phone Date

# 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 **ALLOWED** 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.

Parent/Guardian Signature Phone Date

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