Asthma Treatment Plan – Student

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



Triggers Check all items



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

HEALTHY (Green Zone)

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

You have <u>all</u> of these:		e: M	EDICINE	HOW MUCH to take and HOW OFTEN to take it	patient's asthma:
Breathing is good			Advair® HFA 🗌 45, 🗌 115, 🗌 23	02 puffs twice a day	Colds/flu
	• No cough or wheeze		Aerospan [™]	1,	Exercise
A Las	🖗 • Sleep through		Alvesco [®] □ 80, □ 160	$_$ 1, \Box 2 puffs twice a day	□ Allergens
d'and i	the night		Dulera [®] \square 100, \square 200 $_$	2 puffs twice a day 2 puffs twice a day	⊖ Dust Mites,
H Con	 Can work, exercise, 		1000 100 220 - 100 220 - 100 220 - 100 220 - 10	$\square 1 \square 2$ pulls twice a day	dust, stuffed
50	and play		Symbicort [®] \Box 80. \Box 160	1, _ 2 puffs twice a day 1, _ 2 puffs twice a day	animals, carpet
2			Advair Diskus [®] 🗌 100, 🗌 250, 🗌	5001 inhalation twice a day	 Pollen - trees, grass, weeds
			Asmanex [®] Twisthaler [®] \Box 110, \Box 2	5001 inhalation twice a day 2201 , 1 2 inhalations 🗆 once or 🗆 twice a day	⊖ Mold
			Flovent® Diskus® 🗌 50 🔲 100 🗌	2501 inhalation twice a day	 Pets - animal
			Pulmicort Flexnaler® 🛄 90, 🛄 180	0 1, _ 2 inhalations _ once or _ twice a day 25, _ 0.5, _ 1.01 unit nebulized _ once or _ twice a day	dander
			Singulair [®] (Montelukast) \Box 4, \Box 5,	\Box 10 mg 1 tablet daily	 Pests - rodents, cockroaches
			Other		Good (Irritants)
And/or Peak	flow above		None		\odot Cigarette smoke
			Bemember	to rinse your mouth after taking inhaled medicine.	& second hand
	If exercise triggers	s vour a		puff(s)minutes before exercise.	31110KG
		, your a			cleaning
CAUTION	(Yellow Zone)	\rightarrow	Continue daily control me	dicine(s) and ADD quick-relief medicine(s).	products,
		Y	Continue daily control me		scented products
	You have <u>any</u> of the • Cough	Se: M	EDICINE	HOW MUCH to take and HOW OFTEN to take it	 Smoke from
(Mild wheeze		Albuterol MDI (Pro-air® or Proven	til [®] or Ventolin [®]) _2 puffs every 4 hours as needed	burning wood, inside or outside
e			□ Xopenex®2 puffs every 4 hours as needed		
	• Tight chest		Albuterol 🗌 1.25, 🗌 2.5 mg	Weather Sudden	
• Coughing at night			Duoneb [®]	temperature	
• Other:			Xopenex [®] (Levalbuterol) \Box 0.31, \Box	change o Extreme weather	
	Combivent Respirat [®]				
			Increase the dose of, or add:	 hot and cold Ozone alert days 	
15-20 minutes of has been used more than			Gezene dient daye		
2 times and symptoms persist, call your doctor or go to the emergency room. • If quick-relief medicine is needed more than 2 times a				o	
And/or Peak flow from to week, except before exercise, then call your doctor.					o
					o
EMERGE	NCY (Red Zone)		Take these med	licines NOW and CALL 911.	Other:
Cartille	Your asthma is			-threatening illness. Do not wait!	o
	getting worse fast:		MEDICINE	HOW MUCH to take and HOW OFTEN to take it	o
	• Quick-relief medicine				00
KIT	not help within 15-20 minutes • Breathing is hard or fast U Albuterol MDI (Pro-air® or Proventil® or Ventolin®)4 puffs every 20 minutes 4 puffs every 20 minutes				This asthma treatment
THE SAME	Breathing is hard or fast A puffs every 20 minutes Albuterol 1.25, 2.5 mg1 unit nebulized every 20 minutes			1 unit nebulized every 20 minutes	plan is meant to assist,
	• Trouble walking and talking • Trouble walking and talking			1 unit nebulized every 20 minutes	not replace, the clinical
And/or	• Lips blue • Fingernail		□ Xopenex [®] (Levalbuterol) □ 0.31		decision-making
Peak flow	Other:		Combivent Respimat [®]	1 inhalation 4 times a day	required to meet
below			□ Other		individual patient needs.
provided on an "as is" basis. The American Lun	NJ Asthma Treatment Plan and its content is at your own risk. The content is ng Association of the Mid-Atlantic (ALAM-A), the Pediatric/Adult Asthma				
limited to the implied warranties or merchantability, ALAM-A makes no representations or warranties i	about the accuracy, reliability, completeness, currency, or timeliness of the	ermissio	n to Self-administer Medication:	PHYSICIAN/APN/PA SIGNATURE	DATE
			lent is capable and has been instructed	Physician's Orders	
			oper method of self-administering of the	PARENT/GUARDIAN SIGNATURE	
The Pediatric/Adult Ashma Coalition of New Jersey, sponsored by the American Lung Association in New Jersey. This publication			ebulized inhaled medications named above ordance with NJ Law.		
the authors and do not necessarily represent the official views of the New Jarsey Department of Health and Senior Services or the			student is <u>not</u> approved to self-medicate. PHYSICIAN STAMP		
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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
- Child's date of birth • An Emergency Contact person's name & 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
 - 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
- **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

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ASSOCIATION®

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 ion of the Mid-Atlantic (ALAM-A) the Pediatric/Adul vn risk. The content is provided on an "as is" basis. The American Lunc Sponsored by to mis vession rADA sensing all annuminaria and to commits any approximation. The commits sproved provide a six states. The Annumental Long resolution of the reserve and all affittings disclamal all annumics, express or implicit, statutory or therewise, including but not imited to the implied warranties or not access ALAM makes no representations or warrantiles about the accessing and the annumic and the accessing and pied or error free or that any detects and the correct shaft ALAMA be table for any dranges (including, without imitation, includinatian do correct). anty, rep AMERICAN



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 Parent/Guardian's name & phone number