

Asthma Treatment Plan – Student

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



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AMERICAN LUNG ASSOCIATION
IN NEW JERSEY



(Please Print)

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

HEALTHY (Green Zone) IIII



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 _____

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

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
<input type="checkbox"/> Advair® HFA <input type="checkbox"/> 45, <input type="checkbox"/> 115, <input type="checkbox"/> 230	_____ 2 puffs twice a day
<input type="checkbox"/> Aerospan™	<input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs twice a day
<input type="checkbox"/> Alvesco® <input type="checkbox"/> 80, <input type="checkbox"/> 160	<input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs twice a day
<input type="checkbox"/> Dulera® <input type="checkbox"/> 100, <input type="checkbox"/> 200	_____ 2 puffs twice a day
<input type="checkbox"/> Flovent® <input type="checkbox"/> 44, <input type="checkbox"/> 110, <input type="checkbox"/> 220	_____ 2 puffs twice a day
<input type="checkbox"/> Qvar® <input type="checkbox"/> 40, <input type="checkbox"/> 80	<input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs twice a day
<input type="checkbox"/> Symbicort® <input type="checkbox"/> 80, <input type="checkbox"/> 160	<input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs twice a day
<input type="checkbox"/> Advair Diskus® <input type="checkbox"/> 100, <input type="checkbox"/> 250, <input type="checkbox"/> 500	_____ 1 inhalation twice a day
<input type="checkbox"/> Asmanex® Twisthaler® <input type="checkbox"/> 110, <input type="checkbox"/> 220	<input type="checkbox"/> 1, <input type="checkbox"/> 2 inhalations <input type="checkbox"/> once or <input type="checkbox"/> twice a day
<input type="checkbox"/> Flovent® Diskus® <input type="checkbox"/> 50 <input type="checkbox"/> 100 <input type="checkbox"/> 250	_____ 1 inhalation twice a day
<input type="checkbox"/> Pulmicort Flexhaler® <input type="checkbox"/> 90, <input type="checkbox"/> 180	<input type="checkbox"/> 1, <input type="checkbox"/> 2 inhalations <input type="checkbox"/> once or <input type="checkbox"/> twice a day
<input type="checkbox"/> Pulmicort Respules® (Budesonide) <input type="checkbox"/> 0.25, <input type="checkbox"/> 0.5, <input type="checkbox"/> 1.0	_____ 1 unit nebulized <input type="checkbox"/> once or <input type="checkbox"/> twice a day
<input type="checkbox"/> Singulair® (Montelukast) <input type="checkbox"/> 4, <input type="checkbox"/> 5, <input type="checkbox"/> 10 mg	_____ 1 tablet daily
<input type="checkbox"/> Other	
<input type="checkbox"/> None	

Remember to rinse your mouth after taking inhaled medicine.

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

CAUTION (Yellow Zone) IIII



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.

And/or Peak flow from _____ to _____

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

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
<input type="checkbox"/> Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	_____ 2 puffs every 4 hours as needed
<input type="checkbox"/> Xopenex®	_____ 2 puffs every 4 hours as needed
<input type="checkbox"/> Albuterol <input type="checkbox"/> 1.25, <input type="checkbox"/> 2.5 mg	_____ 1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Duoneb®	_____ 1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Xopenex® (Levalbuterol) <input type="checkbox"/> 0.31, <input type="checkbox"/> 0.63, <input type="checkbox"/> 1.25 mg	_____ 1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Combivent Respimat®	_____ 1 inhalation 4 times a day
<input type="checkbox"/> Increase the dose of, or add:	
<input type="checkbox"/> Other	

• If quick-relief medicine is needed more than 2 times a week, except before exercise, then call your doctor.

EMERGENCY (Red Zone) IIII



Your asthma is 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
- Lips blue • Fingernails blue
- Other: _____

And/or Peak flow below _____

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
<input type="checkbox"/> Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	_____ 4 puffs every 20 minutes
<input type="checkbox"/> Xopenex®	_____ 4 puffs every 20 minutes
<input type="checkbox"/> Albuterol <input type="checkbox"/> 1.25, <input type="checkbox"/> 2.5 mg	_____ 1 unit nebulized every 20 minutes
<input type="checkbox"/> Duoneb®	_____ 1 unit nebulized every 20 minutes
<input type="checkbox"/> Xopenex® (Levalbuterol) <input type="checkbox"/> 0.31, <input type="checkbox"/> 0.63, <input type="checkbox"/> 1.25 mg	_____ 1 unit nebulized every 20 minutes
<input type="checkbox"/> Combivent Respimat®	_____ 1 inhalation 4 times a day
<input type="checkbox"/> Other	

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
 - 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 decision-making required to meet individual patient needs.

Disclaimer: The use of this Asthma Action Plan is intended to assist in the control of your child's asthma. It is not a substitute for medical care. The American Lung Association (ALA) is a national organization that provides information and support for people with asthma. ALA is not responsible for the accuracy or completeness of the information provided in this plan. The use of this plan is at the user's discretion. The user assumes all liability for the use of this plan. The user should consult with their physician for more information. © 2017 American Lung Association. All rights reserved. This document is provided for informational purposes only. It is not intended to be used as a substitute for professional medical advice, diagnosis, or treatment. Always seek the advice of your physician or other qualified health provider with any questions you may have regarding a medical condition. Never disregard professional medical advice or delay in seeking it because of something you have read in this document. Revised May 2017.

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

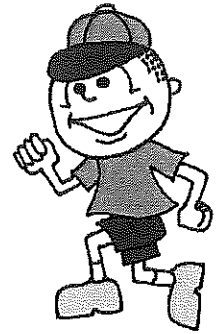
PARENT/GUARDIAN SIGNATURE _____

PHYSICIAN STAMP

REVISED MAY 2017
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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 date of birth
 - Child's doctor's name & phone number
 - An Emergency Contact person's name & phone number
 - Parent/Guardian'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

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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