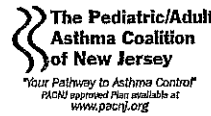


# Asthma Treatment Plan – Student

(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	Parent/Guardian (if applicable)		Emergency Contact
Phone	Phone		Phone

## HEALTHY (Green Zone)



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"/> 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 <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 <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 <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 this medicine \_\_\_\_\_ minutes before exercise.

## 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:
  - \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_

## CAUTION (Yellow Zone)



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"/> Combivent® <input type="checkbox"/> Maxair® <input type="checkbox"/> Xopenex® _____	2 puffs every 4 hours as needed
<input type="checkbox"/> Ventolin® <input type="checkbox"/> Pro-Air® <input type="checkbox"/> Proventil® _____	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"/> 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)



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"/> Combivent® <input type="checkbox"/> Maxair® <input type="checkbox"/> Xopenex® _____	2 puffs every 20 minutes
<input type="checkbox"/> Ventolin® <input type="checkbox"/> Pro-Air® <input type="checkbox"/> Proventil® _____	2 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"/> Other _____	

This asthma treatment plan is meant to assist, not replace, the clinical decision-making required to meet individual patient needs.

Physician's Orders: This form is to be filled out by the physician or other qualified health care provider. It is not to be used as a substitute for a written prescription. The information on this form is for informational purposes only and does not constitute a medical recommendation. The information on this form is for informational purposes only and does not constitute a medical recommendation. The information on this form is for informational purposes only and does not constitute a medical recommendation.

**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 \_\_\_\_\_

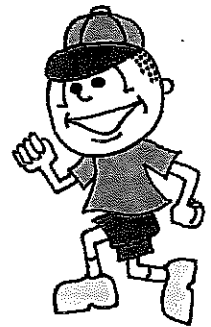
PARENT/GUARDIAN SIGNATURE \_\_\_\_\_

PHYSICIAN STAMP \_\_\_\_\_

**Save**

**Print**

# 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 & 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

## STUDENT AUTHORIZATION FOR SELF ADMINISTRATION OF ASTHMA MEDICATION

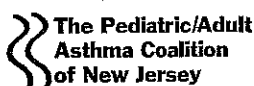
**RECOMMENDATIONS ARE EFFECTIVE FOR ONE (1) SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY**

- 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



**The Pediatric/Adult  
Asthma Coalition  
of New Jersey**  
"Your Pathway to Asthma Control"  
PACNJ approved Plan available at  
[www.pacnj.org](http://www.pacnj.org)

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