Asthma Treatment Plan – Student

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



NJHealth

(Please	Print)
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HEALTHY (Green Zone) IIII Take daily control medicine(s). Some inhalers may be Trigg						
Phone		Phone		Phone		
Doctor		Parent/Guardian (if app	licable)	Emerg	ency Contact	
Name			Date of Birth		Effective Date	

	(0.000.2010)	·····	more effective with a	"spacer" – use if directed.	Check all items
0	You have <u>all</u> of th	ese:	MEDICINE	HOW MUCH to take and HOW OFTEN to take it	that trigger patient's asthma:
12-31	Breathing is good		Advair® HFA 🗌 45, 🗌 115, 🗌 23	02 puffs twice a day	□ Colds/flu
Dion	No cough or wheez	e I	_ Aerospan™	□ 1 □ 2 puffs twice a day □ 1 □ 2 puffs twice a day □ 1 □ 2 puffs twice a day	Exercise
to the	Sleep through the night		_ Alvesco® 60, 160 ∃ Dulera® □ 100 □ 200	2 puffs twice a day	Allergens
0	the night		\Box Flovent [®] \Box 44, \Box 110, \Box 220	2 puffs twice a day 2 puffs twice a day	 Dust Mites,
mark.	Can work, exercise,	, [□ Qvar® □ 40, □ 80	\square 1 \square 2 puffs twice a day	dust, stuffed animals, carpet
	and play		□ Symbicort [®] □ 80, □ 160	□ 1 □ 2 puffs twice a day □ 1 □ 2 puffs twice a day 5001 inhalation twice a day	○ Pollen - trees,
			🗋 Advair Diskus® 🔲 100, 🔲 250, 🗌	5001 inhalation twice a day	arace weeds
			□ ASMANEX [®] IWISTNAIER [®] □ 110, □ 2 □ Elovent [®] Diskus [®] □ 50 □ 100 □	220 1 □ 2 inhalations once twice a day 2501 inhalation twice a day 0 1 □ 2 inhalations once twice a day	o Mold
			\neg Pulmicort Flexhaler [®] \Box 90. \Box 18	$0 \qquad \square 1 \square 2$ inhalations \square once \square twice a day	O Pets - animal dander
			Pulmicort Respules [®] (Budesonide) 0.2	25, 🗌 0.5, 🗌 1.0 1 unit nebulized 🗌 once 🔄 twice a day	 Pests - rodents,
			🗌 Singulair® (Montelukast) 🗌 4, 🔲 5,	□ 10 mg1 tablet daily	cockroaches
			☐ Other		Odors (Irritants)
And/or Peak	flow above	[L	□ None		□ ○ Cigarette smoke
				to rinse your mouth after taking inhaled medicin	e. & second hand smoke
	If exercise trigg	ers your	asthma, take	puff(s)minutes before exercis	e. O Perfumes,
					cleaning
CAUTION	(Yellow Zone)		Continue daily control me	dicine(s) and ADD quick-relief medicine(s).	products, scented
A	You have <u>any</u> of t	these:			products
200	• Cough		MEDICINE	HOW MUCH to take and HOW OFTEN to take it	Smoke from
6.9	 Mild wheeze 		Albuterol MDI (Pro-air® or Proven	burning wood, inside or outside	
and	 Tight chest] Xopenex®	2 puffs every 4 hours as needed	Weather
St on	Coughing at night		🗌 Albuterol 🗌 1.25, 🔲 2.5 mg	1 unit nebulized every 4 hours as neede	d 🛛 🔾 Sudden
-1-1	Other:	_ [Duoneb [®]	1 unit nebulized every 4 hours as neede	d temperature d change
96				0.63, \square 1.25 mg _1 unit nebulized every 4 hours as needed	d O Extreme weather
If quick-relief m	edicine does not help w			1 inhalation 4 times a day	- hot and cold
	or has been used more t	than I L	Increase the dose of, or add:		\odot Ozone alert days
	nptoms persist, call you] Other		Foods:
doctor or go to	the emergency room.	•		ne is needed more than 2 times a	0
And/or Peak fl	ow from to		week, except before	exercise, then call your doctor.	
EMEDCE			— • • •		○ □ 0ther:
EWIERGEI	NCY (Red Zone)			dicines NOW and CALL 911	
200	Your asthma is		Asthma can be a life	-threatening illness. Do not wait!	o
1. IN	 getting worse fas Quick-relief medici 		MEDICINE	HOW MUCH to take and HOW OFTEN to take	
(HE	not help within 15-2		Albuterol MDI (Pro-air® or Pro	oventil® or Ventolin®)4 puffs every 20 minutes	
	Breathing is hard o		□ Xopenex [®]	4 puffs every 20 minutes 1 unit nebulized every 20 minutes	This asthma treatment
ATH	Nose opens wide	Ribs show			
600	Trouble walking an		Duoneb [®]	1 unit nebulized every 20 minutes	not replace, the clinical
And/or	Lips blue • Fingern	nails blue		, \Box 0.63, \Box 1.25 mg <u>1</u> unit nebulized every 20 minutes	decision-making required to meet
Peak flow	• Other:		Combivent Respimat [®] Combivent Respimat [®] Combined	1 inhalation 4 times a day	individual patient needs.
below					
provided on an "as is" basis. The American Lung Coalition of New Jersey and all affiliates disclaim all	Asthma Tneatment Plan and its content is at your own risk. The content is Association of the Mid-Atlantic (ALAM-A), the Pediatric/Adult Asthma warranties, express or implied, statutory or otherwise, including but not	Dormiaci	on to Colf administer Medication		DATE
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current: AAA aus charger, speering and the the intervent of the intervent				Save	
			PARENT/GUARDIAN SIGNATURE		
for Disease Control and Prevention under Cooperative the authors and do not necessarily represent the officia	e Agreement 5U59EH000491-5. Its contents are solely the responsibility of al views of the New Jersey Department of Health and Senior Services or the		rdance with NJ Law.		Print
U.S. Centers for Disease Control and Prevention. Alth	In terms of the new decay department of neural net defined devices of the ough this document has been funded wholly or in part by the United States B2096601-2 to the American Lung Association in New Jessy, this not gone therefore, may not necessarily reflect the views of the Agency and no official	This st	udent is <u>not</u> approved to self-medicate.	PHYSICIAN STAMP	
endorsement should be inferred. Information in this p	ublication is not intended to diagnose health problems or take the place of				

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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 doctor's name & phone number

- Child's name
 - 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

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

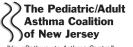
□ I do request that my child be **ALLOWED** to carry the following medication for self-administration in school pursuant to N.J.A.C:.6A:16-2.3. I give permission for my child to self-administer medication, as prescribed in this Asthma Treatment Plan for the current school year as I consider him/her to 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

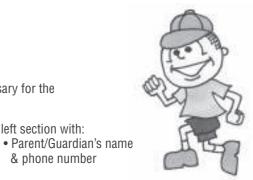


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Your Pathway to Asthma Control PACNJ approved Plan availa www.pacnj.org

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