

Asthma Treatment Plan – Student

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

The Pediatric/Adult Asthma Coalition of New Jersey
 "Your Pathway to Asthma Control"
 PACNJ approved Plan available at
 www.pacnj.org

Sponsored by AMERICAN LUNG ASSOCIATION IN NEW JERSEY

NJ Health New Jersey Department of Health



(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"/> Aerospin™ _____ | <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.

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"/> 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) ||||➡



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 _____ | |

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

Disclaimers: The use of this WebSite/PACNJ Asthma Treatment Plan and its content is at your own risk. The content is provided on an "as is" basis. The American Lung Association of the Mid-Atlantic (ALAMA), the Pediatric/Adult Asthma Coalition of New Jersey and its affiliates disclaim all warranties, express or implied, statutory or otherwise, including but not limited to the implied warranties of merchantability, non-infringement of third parties' rights, and fitness for a particular purpose. ALAMA makes no representation or warranty about the accuracy, reliability, completeness, currency, or timeliness of the content. ALAMA makes no warranty, representation or guarantee that the information will be uninterrupted or error free or that any defects can be corrected. In no event shall ALAMA be liable for any damages (including, without limitation, incidental and consequential damages, personal injury/wrongful death, lost profits, or damages resulting from data or business interruption) resulting from the use or inability to use the content of this Asthma Treatment Plan whether based on warranty, contract, tort, or any other legal theory, and whether or not ALAMA is advised of the possibility of such damages. ALAMA and its affiliates are not liable for any claim, whatsoever, caused by your use or misuse of the Asthma Treatment Plan, nor of this website.

The Pediatric/Adult Asthma Coalition of New Jersey, sponsored by the American Lung Association in New Jersey. This publication was supported by a grant from the New Jersey Department of Health and Senior Services, with funds provided by the U.S. Centers for Disease Control and Prevention under Cooperative Agreement 5U49CE000491-5. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the New Jersey Department of Health and Senior Services or the U.S. Centers for Disease Control and Prevention. Although this document has been funded wholly or in part by the United States Environmental Protection Agency under Agreement XA905601-2 to the American Lung Association in New Jersey, it has not gone through the Agency's publication review process and therefore, may not necessarily reflect the views of the Agency and no official endorsement should be inferred. Information in this publication is not intended to diagnose health problems or take the place of medical advice. For asthma or any medical condition, seek medical advice from your child's or your health care professional.

REVISED AUGUST 2014
 Permission to reproduce blank form - www.pacnj.org

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

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 & 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

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