# Asthma Treatment Plan – Student

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

PACNJ Pediatric/Adult Asthma Coalition

Sponsored by American Lung Association in New Jersey

NJ Health New Jersey Department of Health

**(Please Print)**

| Name | Date of Birth | Effective Date |
|---|---|---|
| Doctor<br>Phone | Parent/Guardian (if applicable)<br>Phone | Emergency Contact<br>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 |
|---|---|
| ☐ Advair® HFA ☐ 45, ☐ 115, ☐ 230 | 2 puffs twice a day |
| ☐ Aerospan™ | ☐ 1, ☐ 2 puffs twice a day |
| ☐ Alvesco® ☐ 80, ☐ 160 | ☐ 1, ☐ 2 puffs twice a day |
| ☐ Dulera® ☐ 100, ☐ 200 | 2 puffs twice a day |
| ☐ Flovent® ☐ 44, ☐ 110, ☐ 220 | 2 puffs twice a day |
| ☐ Qvar® ☐ 40, ☐ 80 | ☐ 1, ☐ 2 puffs twice a day |
| ☐ Symbicort® ☐ 80, ☐ 160 | ☐ 1, ☐ 2 puffs twice a day |
| ☐ Advair Diskus® ☐ 100, ☐ 250, ☐ 500 | 1 inhalation twice a day |
| ☐ Asmanex® Twisthaler® ☐ 110, ☐ 220 | ☐ 1, ☐ 2 inhalations ☐ once or ☐ twice a day |
| ☐ Flovent® Diskus® ☐ 50 ☐ 100 ☐ 250 | 1 inhalation twice a day |
| ☐ Pulmicort Flexhaler® ☐ 90, ☐ 180 | ☐ 1, ☐ 2 inhalations ☐ once or ☐ twice a day |
| ☐ Pulmicort Respules® (Budesonide) ☐ 0.25, ☐ 0.5, ☐ 1.0 | 1 unit nebulized ☐ once or ☐ twice a day |
| ☐ Singulair® (Montelukast) ☐ 4, ☐ 5, ☐ 10 mg | 1 tablet daily |
| ☐ Other | |
| ☐ None | |

***Remember to rinse your mouth after taking inhaled medicine.***

**If exercise triggers your asthma, take_____ ____ puff(s) ____minutes before exercise.**

## 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 |
|---|---|
| ☐ Albuterol MDI (Pro-air® or Proventil® or Ventolin®) | 2 puffs every 4 hours as needed |
| ☐ Xopenex® | 2 puffs every 4 hours as needed |
| ☐ Albuterol ☐ 1.25, ☐ 2.5 mg | 1 unit nebulized every 4 hours as needed |
| ☐ Duoneb® | 1 unit nebulized every 4 hours as needed |
| ☐ Xopenex® (Levalbuterol) ☐ 0.31, ☐ 0.63, ☐ 1.25 mg | 1 unit nebulized every 4 hours as needed |
| ☐ Combivent Respimat® | 1 inhalation 4 times a day |
| ☐ Increase the dose of, or add: | |
| ☐ 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 |
|---|---|
| ☐ Albuterol MDI (Pro-air® or Proventil® or Ventolin®) | 4 puffs every 20 minutes |
| ☐ Xopenex® | 4 puffs every 20 minutes |
| ☐ Albuterol ☐ 1.25, ☐ 2.5 mg | 1 unit nebulized every 20 minutes |
| ☐ Duoneb® | 1 unit nebulized every 20 minutes |
| ☐ Xopenex® (Levalbuterol) ☐ 0.31, ☐ 0.63, ☐ 1.25 mg | 1 unit nebulized every 20 minutes |
| ☐ Combivent Respimat® | 1 inhalation 4 times a day |
| ☐ 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.



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**REVISED AUGUST 2014** **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

**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 _____

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



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