Asthma Treatment Plan

(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"
Original PACNJ approved Plan available at www.pacnj.org

Sponsored by AMERICAN LUNG ASSOCIATION® of New Jersey

NEW JERSEY DEPARTMENT OF HEALTH and SENIOR SERVICES

(Please Print)

Name	Date of Birth	Effective Date

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

HEALTHY

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 medicine(s). All metered dose inhalers (MDI) to be used with spacers.

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Advair® 100, 250, 500	1 inhalation twice a day
☐ Advair® HFA 45, 115, 230	2 puffs MDI twice a day
☐ Asmanex® Twisthaler® 110, 220	1 - 2 inhalations a day
☐ Flovent® 44, 110, 220	2 inhalations twice a day
☐ Flovent® Diskus® 50 mcg	1 inhalation twice a day
☐ Pulmicort Flexhaler® 90, 180	1 - 2 inhalations once or twice a day
☐ Pulmicort Respules® 0.25, 0.5, 1.0	1 unit nebulized once or twice a day
☐ Qvar® 40, 80	2 inhalations twice a day
☐ Singulair 4, 5, 10 mg	1 tablet daily
☐ Symbicort® 80, 160	2 puffs MDI twice a day
☐ Other	

Remember to rinse your mouth after taking inhaled medicine.

If exercise triggers your asthma, take this medicine_____ ____minutes before exercise.

CAUTION

You have *any* of these:
- Exposure to known trigger
- Cough
- Mild wheeze
- Tight chest
- Coughing at night
- Other:_____

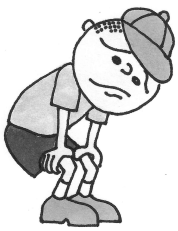
And/or Peak flow from_____ to_____

Continue daily medicine(s) and add fast-acting medicine(s).

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Accuneb® 0.63, 1.25 mg	1 unit nebulized every 4 hours as needed
☐ Albuterol 1.25, 2.5 mg	1 unit nebulized every 4 hours as needed
☐ Albuterol ☐ Pro-Air ☐ Proventil®	2 puffs MDI every 4 hours as needed
☐ Ventolin® ☐ Maxair ☐ Xopenex®	2 puffs MDI every 4 hours as needed
☐ Xopenex® 0.31, 0.63, 1.25 mg	1 unit nebulized every 4 hours as needed
☐ Increase the dose of, or add:	

➡ **If fast-acting medicine is needed more than 2 times a week, except before exercise, then call your doctor.**

EMERGENCY



Your asthma is getting worse fast:
- Fast-acting medicine did not help within 15-20 minutes
- Breathing is hard and fast
- Nose opens wide
- Ribs show
- Trouble walking and talking
- Lips blue • Fingernails blue

And/or Peak flow below _____

Take these medicines NOW and call 911.

Asthma can be a life-threatening illness. Do not wait!

☐ Accuneb® 0.63, 1.25 mg	1 unit nebulized every 20 minutes
☐ Albuterol 1.25, 2.5 mg	1 unit nebulized every 20 minutes
☐ Albuterol ☐ Pro-Air ☐ Proventil®	2 puffs MDI every 20 minutes
☐ Ventolin® ☐ Maxair ☐ Xopenex®	2 puffs MDI every 20 minutes
☐ Xopenex® 0.31, 0.63, 1.25 mg	1 unit nebulized every 20 minutes
☐ Other	

Triggers

Check all items that trigger patient's asthma:

- ❑ Chalk dust
- ❑ Cigarette Smoke & second hand smoke
- ❑ Colds/Flu
- ❑ Dust mites, dust, stuffed animals, carpet
- ❑ Exercise
- ❑ Mold
- ❑ Ozone alert days
- ❑ Pests - rodents & cockroaches
- ❑ Pets - animal dander
- ❑ Plants, flowers, cut grass, pollen
- ❑ Strong odors, perfumes, cleaning products, scented products
- ❑ Sudden temperature change
- ❑ Wood Smoke
- ❑ 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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EFFECTIVE MARCH 2008

FOR MINORS ONLY:

☐ This student is capable and has been instructed in the proper method of self-administering of the 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

Make a copy for patient and for physician file. For children under 18, send original to school nurse or child care provider.

SCOTCH PLAINS FANWOOD PUBLIC SCHOOLS

Request for Self-Administration of Medication

CHILD'S NAME_____GRADE_____

PHYSICIAN'S SECTION

I am requesting that the above named student who has a potentially life-threatening illness be allowed to carry and self-administer the following asthma inhalers as per the prescribed ASTHMA ACTION PLAN.

Name(s) of medications:_____

Possible side effects of medication/or special precautions to be taken: _____

Conditions under which self-administration will take place: (check as many as apply)

_____ **Independently:** Child has been trained and is proficient in self-administering medication and is aware that he/she may not share the medication with anyone else. Medication should be in student's possession. **Students in grade K-2 are <u>not</u> eligible for independent self-medication.**

_____ **Self-administered under the supervision of the school nurse.** (The nurse is on duty during school hours only.) Medication will be kept in the nurse's office.

_____ **Medication will be administered by the nurse**. (The nurse is on duty during school hours only.) Medication will be kept in the nurse's office.

_____ _____
Physician's Name (print or stamp) Physician's Signature

_____ _____ _____
Telephone Number Fax Number Date

PARENT'S SECTION

I give permission for my child's medications to be administered as ordered in the ASTHMA ACTION PLAN and by the method listed above while on school property or off school property at an approved school event. I will notify the school nurse if this medication is no longer required or self-administration is no longer directed by the physician. The medication is to be provided by me in the original labeled container. A duplicate of this medication is to be sent into and kept in the nurse's office. To my knowledge, my child is not allergic to this medication.

I hereby release and hold harmless the Board, its agents, servants, and employees from any and all liability for injuries or other damages which may result to the student, his/her servants and representatives from administration of the medication provided proper procedures are followed.

_____ _____
Parent/ Guardian's Signature Date

STUDENT'S SECTION-for independent self administration only

I understand that I will use my asthma medication as directed by my physician in the ASTHMA ACTION PLAN. I will be responsible and discreet in its use and have it readily available.

I have been instructed how to self –administer this medication and understand the side effects of improper use. The medication must be carried in the original labeled pharmacy container and may not be shared with anyone else. After each use I will notify the school nurse.

I understand that if I do not abide by these regulations I may forfeit my right to carry and self-administer this medication. I understand that this contract is to be renewed annually at the beginning of each school year.

_____ _____
Student's Signature Date

Reviewed by School Medical Director Date