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)

Take daily control medicine(s). Some inhalers may be more effective with a "spacer" – use if directed.

You have *all* of these:
- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work, exercise, and play

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 ☐ twice a day
☐ Flovent® Diskus® ☐ 50 ☐ 100 ☐ 250 ____	1 inhalation twice a day
☐ Pulmicort Flexhaler® ☐ 90, ☐ 180 ____	☐ 1 ☐ 2 inhalations ☐ once ☐ twice a day
☐ Pulmicort Respules® (Budesonide) ☐ 0.25, ☐ 0.5, ☐ 1.0 __	1 unit nebulized ☐ once ☐ twice a day
☐ Singulair® (Montelukast) ☐ 4, ☐ 5, ☐ 10 mg ____	1 tablet daily
☐ Other	
☐ None	

And/or Peak flow above ________

Remember to rinse your mouth after taking inhaled medicine.

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

CAUTION (Yellow Zone)

Continue daily control medicine(s) and ADD quick-relief medicine(s).

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______

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)

Take these medicines NOW and CALL 911.
Asthma can be a life-threatening illness. Do not wait!

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 ________

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

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

Save

Print

Make a copy for parent and for physician file, send original to school nurse or child care provider.

Print Medicines Only

SCOTCH PLAINS-FANWOOD PUBLIC SCHOOLS
DEPARTMENT OF SPECIAL SERVICES
667 Westfield Road
Scotch Plains, New Jersey 07076
(908) 889-0100
Fax (908) 889-1812

DIRECTOR OF SPECIAL SERVICES
Linda Edwards

SUPERVISOR OF EDUCATION
Diane Peneno

PHYSICIAN AUTHORIZATION

See check off box on bottom left of front page. Indicate if student is permitted to self medicate. **Only students in grade 3-12 are eligible to self administer medication.**

STUDENT'S SECTION-for independent self-administration grades 3-12 only.

I understand that I will use my medication for asthma as directed by my physician in the ASTHMA TREATMENT 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 _____

Rev: 12/13

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 _____

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