## Asthma Treatment Plan — Student (This asthma action plan meets NJ Law N.J.S.A. 18A:40-12.8) (Physician's Orders)







(Please Pr	int)						
Name			and said . Contain	Date of Birth	45 3	Effective Date	n = 2 1
Doctor			Parent/Guardian (if app	olicable)	Emerg	gency Contact	
Phone	-	12	Phone	-ara e table grad	Phone		177
HEALTHY	(Green Zone)		ake daily control mo				Triggers Check all items
	You have all of the	nese: ME	DICINE	HOW MUCH to ta	ake and HOW	OFTEN to take it	that trigger patient's asthma:
di Jest	<ul> <li>Breathing is good</li> </ul>		DICINE	30 2 p	uffs twice a da	V T a la l	D Coldo #III
( )	<ul> <li>No cough or wheez</li> </ul>	ze 🗀 A	erospan™		1, $\square$ 2 puffs to	vice a day	□ Colds/flu □ Exercise
(2)	<ul> <li>Sleep through</li> </ul>		lvesco® 🗆 80, 🗆 160	medical a be	1, ☐ 2 puffs to	vice a day	Allergens
	the night		oulera® □ 100, □ 200	2 p	ouffs twice a da	y	O Dust Mites,
DET H	<ul> <li>Can work, exercise,</li> </ul>	,  남;	10vent° □ 44, □ 110, □ 220 _ 1var® □ 40 □ 80	2 p	1 $\square$ 2 nuffs tw	ice a day	dust, stuffed
	and play	١٣٤	wmbicort® □ 80. □ 160	EX BATTLE TOTAL	1. □ 2 puffs tw	vice a day	animals, carpet
			dvair Diskus® 🔲 100, 🖂 250, 🖂	□ 5001 ir	nhalation twice	a day	<ul> <li>Pollen - trees, grass, weeds</li> </ul>
			smanex® Twisthaler® 🔲 110, 🔲	220	1, 🗌 2 inhalatio	ons 🗖 once or 🔲 twice a day	o Mold
			lovent® Diskus® 🔲 50 🔲 100 🗀	□ 2501 ir	nhalation twice	a day	o Pets - animal
			ulmicort Flexhaler® 🔲 90, 🔲 18 ulmicort Respules® (Budesonide) 🔲 0	025 - 05 - 10 11	1, ∐ 2 Innaiatio	ons in once or in twice a day	dander
			ingulair® (Montelukast) 🗌 4, 🔲 5,			J OHOE OF TWICE & day	O Pests - rodents, cockroaches
			other	, , to mg , a	abiot daily		Odors (Irritants)
And/or Peak	flow above		lone 15-10-10-10-10-10-10-10-10-10-10-10-10-10-				O Cigarette smoke
	The state of the s	- 1	Remember	to rinse vour mo	uth after tak	ing inhaled medicine	& second hand
	If exercise trigge	ers vour as				utes before exercise.	
	10211021	mar ye priser		Article service in the latest	17-		cleaning
CAUTION	(Yellow Zone) ll		continue daily control me	edicine(s) and A	DD quick-re	elief medicine(s).	products, scented
	You have <u>any</u> of t	hese:	The second secon				products
g and a second	• Cough	ME	DICINE	HOW MUCH to ta	ke and HOW	OFTEN to take it	o Smoke from
3_1	Mild wheeze		Ibuterol MDI (Pro-air® or Prove	ntil® or Ventolin®) _2	2 puffs every 4	hours as needed	burning wood, inside or outside
	Tight chest	□×	openex®  buterol	to be all the fillings that the property of	2 puffs every 4	hours as needed	□ Weather
	Coughing at night		lbuterol □ 1.25, □ 2.5 mg	face make the face of	1 unit nebulized	every 4 hours as needed	O Sudden
~ ( )	Other:		uoneb®	26 sector handles i ont	unit nebulized	every 4 hours as needed	temperature
TY.	Othor	-  □×	openex® (Levalbuterol) □ 0.31, □				change
of avials malias man	uliaina dana nat halis w	: <sub>*bin</sub>   □ 0	ombivent Respimat®	1	I inhalation 4 ti	mes a day	<ul> <li>Extreme weather</li> <li>hot and cold</li> </ul>
	dicine does not help wi	IIIIII   1.	crease the dose of, or add:				O Ozone alert days
5-20 minutes of has been used more than						☐ Foods:	
z tilles alla symptoms persist, can your						0	
				ek, except before exercise, then call your doctor.			0
rand/of 1 dan no							°
EMERGEN	CY (Red Zone)		Take these me	dicines No	OW and	I CALL 911.	Other:
ONTHE S	Your asthma is		Asthma can be a life				0
getting worse fast:				0			
1	<ul> <li>Quick-relief medicir</li> </ul>	ie uiu   ;	MEDICINE  HOW MUCH to take and HOW OFTEN to take it  Albuterol MDI (Pro-air® or Proventil® or Ventolin®)4 puffs every 20 minutes				
JETT	not help within 15-2					very 20 minutes	This asthma treatment
	<ul> <li>Breathing is hard or</li> <li>Nose opens wide • I</li> </ul>	Rihe chow	□ Xopenex® □ Albuterol		1 unit nel	oulized every 20 minutes	plan is meant to assist,
aa	Trouble walking an	d talking	□ Duoneb®		1 unit nel	oulized every 20 minutes	not replace, the clinical
And/or	• Lips blue • Fingern	ails blue	☐ Xopenex® (Levalbuterol) ☐ 0.31	, □ 0.63, □ 1.25 mg	g1 unit nel	oulized every 20 minutes	decision-making
Peak flow	• Other:		Combivent Respimat®		1 inhalati	on 4 times a day	required to meet
below		[	☐ Other				individual patient needs.
routed no on "he is" havis. The American Lime Act	ma Statment Plan and its content is all your own risk. The content is activitien of the Mid-Atlantic (M.MA-A), the Pad artic/Adult Antonia						
anifica of New Josep and all at lates disclaim all wa	nation, repress or implied, statutry or otherwise, including but not	Permission t	o Self-administer Medication:	PHYSICIAN/APN/PA S	IGNATURE		DATE
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			ed inhaled medications named above	- ALLEN AGAIDIAN S	AGITAL OFFE		<del>-</del>
s Disease Certical and Provention under Cooperative Ag e authors and do not mosssarily represent the afficial vir S. Certiers for Deasse Certical and Prevention, Athonol	care of the American Service, with furth provided by the US. Centers researed SEGS 000401-6. To content was safely the reprocessibility of each of the four Joney Demander of Health and Service Services or the three document has been furted and by a migrat by the United States 00014-7 in the American Long Secución to Mass Joney Share or gross and the services of the Secución of Mass Joney Share or gross the services of the Secución of Mass Joney Share or gross the Secución of the Secución of Mass Joney Share or gross the Secución of		ce with NJ Law.	PHYSICIAN STA	AMP		
niar semental Protestion Agency under Agreement IASA22 roogh Par Agency's publikations review process and ther	6601-2 in the American Lung Association in New Jestey, it has not gene dam, may not reconstrily reflect the views of the Agency and ma official	☐ This studer	t is <u>not</u> approved to self-medicate.	I III OIOIAN OIF	11411		

REVISED MAY 2017

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
- · Child's date of birth An Emergency Contact person's name & phone number
- & phone number



- 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 <b>ALLOWED</b> to carry the following medication							
☐ I DO NOT request that my child self-administer his/her asthma medication.							
Parent/Guardian Signature	Phone	Date					



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