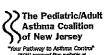
Asthma Treatment Plan - Student

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







our Pathway to Asthma Control
PECNI account Plan emiliatio at (Please Print) Effective Date Date of Birth Name **Emergency Contact** Parent/Guardian (if applicable) Doctor Phone Phone Phone Take daily control medicine(s). Some inhalers may be Triggers HEALTHY (Green Zone) more effective with a "spacer" - use if directed. Check all items that trioger HOW MICH to take and HOW OFTEN to take it You have all of these: MEDICINE patient's asthma: · Breathing is good ☐ Advair® HFA ☐ 45, ☐ 115, ☐ 230 _____ 2 puffs twice a day ☐ Colds/flu _ ☐ 1, ☐ 2 puffs twice a day · No cough or wheeze □ Aerospan™ □ Exercise ☐ Alvesco® ☐ 80, ☐ 160 _____ ____ 🗆 1, 🗆 2 puffs twice a day · Sleep through . ☐ Allergens ☐ Dulera® ☐ 100, ☐ 200 ______2 puffs twice a day ☐ Flovent® ☐ 44, ☐ 110, ☐ 220 ______2 puffs twice a day _2 puffs twice a day the night o Dust Mites, dust, stuffed Can work, exercise, _ 1, □ 2 puffs twice a day ☐ Qvar® ☐ 40, ☐ 80 _ animals, carpet and play ☐ Symbicort® ☐ 80, ☐ 160 _ _____ 1, 🗀 2 puffs twice a day o Polien - trees, ☐ Advair Diskus® ☐ 100, ☐ 250, ☐ 500 ______1 inhalation twice a day grass; weeds ☐ Asmanex® Twisthaler® ☐ 110, ☐ 220 ☐ 1. ☐ 2 inhalations ☐ once or ☐ twice a day o Mold 1 inhalation twice a day ☐ Flovent® Diskus® ☐ 50 ☐ 100 ☐ 250 _____ o Pets - animal _ ☐ 1, ☐ 2 inhalations ☐ once or ☐ twice a day □ Pulmicort Flexhaler® □ 90, □ 180_____ dander ☐ Pulmicort Respules® (Budesonide) ☐ 0.25, ☐ 6.5, ☐ 1.0__ 1 unit nebulized ☐ once or ☐ twice a day o Pests - rodents, ☐ Singulair® (Montelukast) ☐ 4, ☐ 5, ☐ 10 mg _____1 tablet daily cockroaches Odors (Irritants) □ Other o Cigarette smoke ☐ None And/or Peak flow above ___ & second hand Remember to rinse your mouth after taking inhaled medicine. smoke puff(s) ____minutes before exercise. o Perfumes, If exercise triggers your asthma, take_ cleaning products, Continue daily control medicine(s) and ADD quick-relief medicine(s). CAUTION (Yellow Zone) | 11123> scented products You have any of these: HOW MUCH to take and HOW OFTEN to take it MEDICINE o Smoke from Cough burning wood, Albuterol MDI (Pro-air® or Proventil® or Ventolin®) _2 puffs every 4 hours as needed inside or outside Mild wheeze ____2 puffs every 4 hours as needed ☐ Xopenex® ☐ Weather Tight chest ☐ Albuterol ☐ 1.25, ☐ 2.5 mg ______1 unit nebulized every 4 hours as needed ☐ Duoneb® ______1 unit nebulized every 4 hours as needed o Sudden · Coughing at night temperature ☐ Duoneb® _____ • Other:____ change ∑ Xopenex® (Levalbuterol) □ 0.31, □ 0.63, □ 1.25 mg _1 unit nebulized every 4 hours as needed. o Extreme weather □ Combivent Respirat® ______1 inhalation 4 times a day - hot and cold If quick-relief medicine does not help within ☐ Increase the dose of, or add: o Ozone alert days 15-20 minutes or has been used more than ☐ Foods: □ Other 2 times and symptoms persist, call your If quick-relief medicine is needed more than 2 times a doctor or go to the emergency room. week, except before exercise, then call your doctor. And/or Peak flow from_____ to__ Take these medicines NOW and CALL 911. Other: EMERGENCY (Red Zone) || || Asthma can be a life-threatening illness. Do not wait! Your asthma is getting worse fast: HOW MUCH to take and HOW OFTEN to take it Quick-relief medicine did ☐ Albuterol MDI (Pro-air® or Proventil® or Ventolin®) ___4 puffs every 20 minutes not help within 15-20 minutes 4 puffs every 20 minutes This asthma treatment ☐ Xopenex[®] Breathing is hard or fast ☐ Albuterol ☐ 1.25, ☐ 2.5 mg ______1 unit nebulized every 20 minutes ☐ Duppeh® ______1 unit nebulized every 20 minutes plan is meant to assist, Nose opens wide • Ribs show ☐ Duoneb® ______1 unit nebulized every 20 minutes ☐ Xopenex® (Levalbuterol) ☐ 0.31, ☐ 0.63, ☐ 1.25 mg ____1 unit nebulized every 20 minutes not replace, the clinical . Trouble walking and talking decision-making Lips blue • Fingernails blue And/or required to meet □ Combivent Respirat® ______1 inhalation 4 times a day Other: Peak flow individual patient needs. ☐ Other below DATE_ PHYSICIANVAPN/PA SIGNATURE_ Permission to Self-administer Medication: Physician's Orders ☐ This student is capable and has been instructed

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in the proper method of self-administering of the non-nebulized inhaled medications named above in accordance with NJ Law.

☐ This student is <u>not</u> approved to self-medicate.

PARENTÆUKEDIAN SIGNATURE____

PHYSICIAN STAMP

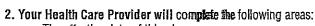
Make a copy for parent and for physician file, send uriginal to school nurse or child care provider.

Asthma Treatment Plan – Student Parent Instructions

The **PACNJ Asihma Treatment Plan is designed** to help everyone understand the steps necessary for the individual student to achieve the goal of controlled asthma.

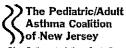
- 1. Parents/Guardians: Before taking this form to your Health Care Provider, complete the top left section with:
 - · Child's name
- · Child's doctor's name & phone number
- Parent/Guardian's name

- · Child's date of birth
- An Ememory 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
 - <u>Permission to Self-administer Medication</u> section at the bottom of the form: Discuss your child's ability to set administer the inhaled medications, check the appropriate box, and then both you and your Health Care Provider must signant 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 knome to help manage your child's asthma
 - Give copies of the Asthma Treatment Plan to everyone who provides care for your child, for example: babysitiens, before/after school program staff. coaches, scout leaders

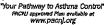
PARENT AUTHORIZATION I hereby give permission for my child to receive medication at school as prescribed in the Asthma Treatment Plan. Medication must be provided in its original prescription container property labeled by a pharmacist or physician. I also give permission for the release and exchange 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 CHAID 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		
☐ I DO NOT request that my child self-administer his/her asthma medication.		
Parent/Guardian Signature	Phone	Date



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