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









(Please Pri	int)			Complete Mark 115th			-	
Name			Date of Birth			Effective Date		
Doctor			Parent/Guardian (if app	licable)	Emerge	ency Contact		
Phone			Phone	Phone				
HEALTHY (Green Zone) Take daily control medicine(s). Some inhalers may be more effective with a "spacer" - use if directed.								
And/or Peak	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 □ 160 □ 1, □ 2 puffs twice a day □ Advalr 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 □ Singulalr® (Montelukast) □ 4, □ 5, □ 10 mg □ 1 tablet daily □ Other □ None				 Pests - rodents, cockroaches Odors (Irritants) 	
Remember to rinse your mouth after taking inhaled medicine. If exercise triggers your asthma, take								
If quick-relief me 15-20 minutes of 2 times and sym doctor or go to to And/or Peak flo	You have any of these Cough Mild wheeze Tight chest Coughing at night Other: edicine does not help withing the been used more than aptoms persist, call your the emergency room.	MEDIC Albu Xope Albu Duo Xope Com Incre Othe	terol MDI (Pro-air® or Provelenex®	scented products Smoke from burning wood, inside or outside Weather Sudden temperature change Extreme weather hot and cold Ozone alert days Foods:				
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:			thma can be a life-threatening illness. Do not wait! DICINE HOW MUCH to take and HOW OFTEN to take it albuterol MDI (Pro-air® or Proventil® or Ventolin®) 4 puffs every 20 minutes (openex® 4 puffs every 20 minutes 1 unit nebulized every 20 minutes 1 unit nebulized every 20 minutes (openex® 1 unit nebulized every 20 minutes 1 unit nebulized every 20 minutes (openex® (Levalbuterol) 0.31, 0.63, 1.25 mg 1 unit nebulized every 20 minutes (openex® (Levalbuterol) 1 inhalation 4 times a day other				This asthma treatment plan is meant to assist, not replace, the clinical decision-making required to meet individual patient needs	
Heard In Indicate inventors in servicios (III), no IRAMA- Anilan e repronentacios II in warman LAMA- Anilan e repropria provincialos II in certas (IIII). A IRAMA- Maria in servicio producto certa (IIII) a IRAMA- IRAMA III in maria del producto certa (IIII) a IRAMA III in maria (IIII) a IRAMA II in certa (IIII) a IRAMA II IN IRAMA II I	when I halved No and is creat in 4 year one do. The created in the control of the	This student is in the proper m	elf-administer Medication: capable and has been instructed lethod of self-administering of the inhaled medications named above with NJ Law.	PARENT/GUARDIAN SIGNAT		Physician's Orders	DATE	

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

- 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
 - <u>Permission to Self-administer Medication</u> 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								
☐ I DO NOT request that my child self-administer his/her asthma medication.								
Parent/Guardian Signature	Phone	Date						



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