## 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)			Timi, paci	n,w <sub>B</sub>		
Name				Date of Birth	Effective Date		
Doctor			Parent/Guardian (if applicable)		Emergency Contact		
Phone			Phone		Phone		
HEALTHY	(Green Zone)	Take	e daily control me e effective with a	edicine(s). Some a "spacer" – use i	inhalers may be f directed.	Triggers Check all items that trigger	
			IEDICINE HOW MUCH to take and HOW OFTEN to take it				
	<ul> <li>Breathing is good</li> <li>No cough or wheeze</li> <li>Sleep through the night</li> <li>Can work, exercise, and play</li> </ul>	☐ Advai ☐ Aeros ☐ Alves ☐ Duler ☐ Flove ☐ Qvar ☐ Symb ☐ Advai ☐ Asma ☐ Flove ☐ Pulmi ☐ Pulmi	dander				
And/or Peak	flow above	☐ Singu ☐ Other ☐ None	llair® (Montelukast) □ 4, □ 5,	☐ 10 mg1 tablet da	aily	<ul> <li>○ Pests - rodents, cockroaches</li> <li>□ Odors (Irritants)</li> <li>○ Cigarette smoke &amp; second hand</li> </ul>	
Remember to rinse your mouth after taking inhaled medicine.  If exercise triggers your asthma, take puff(s)minutes before exercise.							
CAUTION (Yellow Zone)						cleaning products, scented	
	You have <u>any</u> of these:						
9	• Cough	MEDICI			HOW OFTEN to take it	<ul> <li>Smoke from burning wood,</li> </ul>	
(e)	<ul> <li>Mild wheeze</li> </ul>	☐ Albute	erol MDI (Pro-air® or Prover nex®	ntil® or Ventolin®) _2 puffs	every 4 hours as needed	inside or outside	
85	• Tight chest	☐ Albute	erol 🗆 1.25. 🗆 2.5 mg	2 pulls	ebulized every 4 hours as needed	□ Weather	
0	<ul><li>Coughing at night</li><li>Other:</li></ul>	□ Duone	eb®	1 unit ne	ebulized every 4 hours as needed	<ul> <li>Sudden temperature</li> </ul>	
STA.	• Other				ebulized every 4 hours as needed	change	
If quick-relief me	edicine does not help within		ivent Respimat®			<ul> <li>Extreme weathe</li> <li>hot and cold</li> </ul>	
15-20 Illinutes of has been used more than			☐ Increase the dose of, or add:				
2 times and symptoms persist, call your			□ Other				
			If quick-relief medicine is needed more than 2 times a			0	
And/or Peak flow from to week, except before exercise, then call your doctor.					all your doctor.	0	
EMERGENCY (Red Zone) Take these medicines NOW and CALL 911.  Asthma can be a life-threatening illness. Do not wait!					Other:		
3.1	getting worse fast: • Quick-relief medicine did		ICINE		ke and HOW OFTEN to take it	0	
And/or Peak flow below	not help within 15-20 minut  Breathing is hard or fast  Nose opens wide Ribs sho  Trouble walking and talking  Lips blue Fingernails blue  Other:	□ Xo ow □ All g □ Du □ Xo	buterol MDI (Pro-air® or Proventil® or Ventolin®)4 puffs every 20 minutes ppenex®			This asthma treatment plan is meant to assist, not replace, the clinical decision-making required to meet individual patient needs	
Codition of New Jersey and all affiliates disclaim all wa limited to the implied warranties or merchantability, non- ALAM-A makes no representations or warranties about content ALAM-A makes no warranty, representation or or	tre accuracy, relationity, compreseness, cumency, or cineminess of the		f-administer Medication:	PHYSICIAN/APN/PA SIGNATUF		DATE	
defects can be corrected. In no event shall ALAM-A be consequential dramages, personal injury/avongtal draft, insulting from the loss or insulting to use the content of the any other legal theory, and whether or not ALAM-As at not liable for any claim, whatsoever, caused by your use is	Intellé for any damages (modicine), without himitation, incidental and being the configuration protrieg from entities the intellect technical himitage (modified protrieg) in Anthrea Treatment Plans sterilor based on secretary, contest, but no recent of the opposition of sometimes of AnAAA and its artifales are minimized the AnAAAA intellect ETA configuration of the AnAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA	proper met	pable and has been instructed nod of self-administering of the aled medications named above	PARENT/GUARDIAN SIGNATUR	Physician's Orders RE		
was supported by a grant from the New Jursey Department for Disease Control and Prevention under Cooperative Ag the authors and do not recoveryly somework the official or	of Health and Senior Services, with funds provided by the U.S. Contexs neument \$1559F1000491-S. Its contents are salely the responsibility of text of the New Jersey Department of Health and Senior Services on the	ordance wit		PHYSICIAN STAMP	-		

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



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