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				Date of Birth		Effective Date	
Doctor			Parent/Guardian (if appl	icable)	Emergency Contact		
Phone			Phone	Phone			
HEALTHY	(Green Zone)	Tak mo	te daily control me re effective with a	dicine(s). Some "spacer" – use	inhal	ers may be	Triggers Check all items that trigger
	You have <u>all</u> of these:		MEDICINE HOW MUCH to take and HOW OFTEN to take it				
4. (3)	Breathing is goodNo cough or wheeze	Adva	air® HFA 🗌 45, 🔲 115, 🔲 23	0 2 puffs t	twice a da	V	patient's asthma:
- S	Sleep through	☐ Alve	span™sco® □ 80, □ 160		2 puffs to	vice a day vice a dav	□ Exercise
S. L.	the night		190 100 1200	2 nuffe t	twice a da	V	☐ Allergens ○ Dust Mites.
The H	• Can work, exercise,	Qvai	ent®	2 puffs 1	twice a da 2 puffs tw	ly vice a dav	dust, stuffed
DW	and play	☐ Sym	® □ 40, □ 80 bicort® □ 80, □ 160		2 puffs tw	rice a day	animals, carpet > Pollen - trees,
		I Adva	air Diskus® 100. 250.	1 500 1 inhala	tion twice	a day	grass, weeds
		☐ Flov	anex® Twisthaler® 🔲 110, 🗍 : ent® Diskus® 🔲 50 🔲 100 🗀	2501 inhala	tion twice	a day	O Mold O Pets - animal
		Pulm	nicort Flexhaler® □ 90, □ 18 nicort Respules® (Budesonide) □ 0.	0	2 inhalatio	ons once or twice a day	dander
		Sing	ulair® (Montelukast) 🔲 4, 🔲 5,	1 tablet	daily	once or twice a day	 Pests - rodents, cockroaches
And/on Dools	flaalaaa	☐ Othe					□ Odors (Irritants)
And/or Peak	flow above	L NOII		40 ulmaa	- (1 1 - 1		Cigarette smoke & second hand
	If exercise triggers yo	ur asthr				ing inhaled medicine. outes before exercise.	smoke
0.0000000000000000000000000000000000000		o trial of the text			en deskriver av den	THE STATE OF THE S	 Perfumes, cleaning
GAUTION	(Yellow Zone) [>		ntinue daily control me	edicine(s) and ADD	quick-re	elief medicine(s).	products, scented
(Cough			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				
	• Tight chest	☐ Xop	enex®	2 puf	fs every 4	hours as needed	inside or outside
St. Car	 Coughing at night 	☐ Albu	terol 🗌 1.25, 🔲 2.5 mg	1 unit	t nebulized	l every 4 hours as needed	o Sudden
COL	• Other:	Duo	neb®	1 unit	t nebulized	l every 4 hours as needed	temperature change
VW	e	□ Com	enex® (Levalbuterol) □ 0.31, □ bivent Respimat®	0.63, 1.25 mg _1 unit	i nebulized alation 4 ti	mes a day	o Extreme weather
	edicine does not help within or has been used more than	☐ Incr	ease the dose of, or add:		ulation 1 ti	moo u uuy	 hot and cold Ozone alert days
2 times and syn	nptoms persist, call your	☐ Othe					□ Foods:
	the emergency room.		uick-relief medici				0
And/or Peak fl	ow from to	we	ek, except before	exercise, then	call y	our doctor.	0
EMERGEI	NCY (Red Zone)	T	ake these med	dicines NOV	V and	1 CALL 911.	Other:
Caran	Your asthma is		sthma can be a life				0
3	getting worse fast: • Quick-relief medicine did	100000000000000000000000000000000000000	DICINE		-	HOW OFTEN to take it	0
	not help within 15-20 min	utes 🗆	Albuterol MDI (Pro-air® or Pro	oventil® or Ventolin®)	_4 puffs 6	every 20 minutes	0
TOD	 Breathing is hard or fast Nose opens wide Ribs sl 		Xopenex® Albuterol □ 1.25, □ 2.5 mg _		_4 puffs 6	every 20 minutes	This asthma treatment
	 Trouble walking and talki 	na 🗆	Duoneb [©]		_ i unit ne 1 unit ne	bulized every 20 minutes	plan is meant to assist, not replace, the clinical
And/or	 Lips blue • Fingernails bl 	ie 🗆 :	Duoneb [⊚] Xopenex [®] (Levalbuterol) □ 0.31	, 🗆 0.63, 🗆 1.25 mg 🔃	_1 unit ne	bulized every 20 minutes	decision-making
Peak flow below	• Other:	-	Combivent Respimat® Other		_1 inhalat	ion 4 times a day	required to meet individual patient needs
	Norma Tourrest Pleaser is contest a vigo rough for the contest is Accretified at the Medical Pleaser (N. 2011). The Queen for the contest is]
Coalition of New Jersey and all affiliates, facilities all limited to the emption committees or more ramed. By an ALANA makes no my seekfallons or without pages as coalities. A ANA makes			Self-administer Medication:	PHYSICIAN/APN/PA SIGNA			DATE
uniquid pour germe or pargel, prime Le control construcció di Labor tendo, qui vigintality de quata con pe co separ pi en men avril yr Myri en en en en espar pi en en avril yr Myrian en en en en espar pi en en en avril yr Myrian en en en en espar pi en	report of the new more considerations to the contract of the c	s student is	capable and has been instructed			Physician's Orders	
any che legal broop, est schedure i no AAANA è no Fosle to any daim, sita sceno, sa seo ty pour The Positiciae, Alabora Coalida al New Jerge, s	rabunes of the obsolitify of such consepts. ALAN-A as this stiffaire are are of notices or this Astrono Treatment Plan not, of this web-late. NOTIONED by the Amor can Lung, Association in New Jersey, This, Jobbsolice.	ne proper fr n-nebulized	nethod of self-administering of the inhaled medications named above	PARENT/GUARDIAN SIGNA	ATURE		_
was supported by a grant from the New Jersey Depart Let Discore II. And and Princetion under Consentate the subury of the new recording to pre-entities of it will Sceners and Experie II mind on Promotion Admin Letters and Experie II mind on Promotion Admin	Apartical SUSSECCIONS, and last proceed by the (i.e., page) Apartical SUSSECCIONS to access at a bully the term initiality of Informal ten here amy December of malific and Security Survives of the	ccordance	with NJ Law.	DUVOLOUAN STATE			
	809000-1 to the America Lean, Association in Management as a segan to the America Lean Lean Lean Inc. The America Lean Lean Lean Lean Lean Lean Lean Lea	s student is	s <u>not</u> approved to self-medicate.	PHYSICIAN STAME	_		

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