

Asthma Treatment Plan – Studer

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



(Please Print)

Name	Date of Birth	Effective Date
Doctor	Parent/Guardian (if applicable)	Emergency Contact
Phone	Phone	Phone

HEALTHY (Green Zone)



You have all of these:

- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work, exercise, and play

And/or Peak flow above _____

Take daily control medicine(s). Some inhalers may be more effective with a "spacer" – use if directed.

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
# Advair® HFA # 45, # 115, # 230	2 puffs twice a day
# Aerospir™	# 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	# 1, # 2 puffs twice a day
# Symbicort® # 80, # 160	# 1, # 2 puffs twice a day
# Advair 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
# Singulair® (Montelukast) # 4, # 5, # 10 mg	1 tablet daily
# Other	
# None	

Remember to rinse your mouth after taking inhaled medicine.

If exercise triggers your asthma, take _____ puff(s) _____ minutes before exercise.

CAUTION (Yellow Zone)



You have any of these:

- Cough
- Mild wheeze
- Tight chest
- Coughing at night
- Other: _____

If quick-relief medicine does not help within 15-20 minutes or has been used more than 2 times and symptoms persist, call your doctor or go to the emergency room.

And/or Peakflow from _____ to _____

Continue daily control medicine(s) and ADD quick-relief medicine(s).

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
# Xopenex®	2 puffs every 4 hours as needed
# Albuterol # 1.25, # 2.5 mg	1 unit nebulized every 4 hours as needed
# Duoneb®	1 unit nebulized every 4 hours as needed
# Xopenex® (Levalbuterol) # 0.31, # 0.63, # 1.25 mg	1 unit nebulized every 4 hours as needed
# Combivent Respimat®	1 inhalation 4 times a day
# Increase the dose of, or add:	
# Other	
• If quick-relief medicine is needed more than 2 times a week, except before exercise, then call your doctor.	

EMERGENCY (Red Zone)



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: _____

And/or Peak flow below _____

Take these medicines NOW and CALL 911. Asthma can be a life-threatening illness. Do not wait!

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
# Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	4 puffs every 20 minutes
# Xopenex®	4 puffs every 20 minutes
# Albuterol # 1.25, # 2.5 mg	1 unit nebulized every 20 minutes
# Duoneb®	1 unit nebulized every 20 minutes
# Xopenex® (Levalbuterol) # 0.31, # 0.63, # 1.25 mg	1 unit nebulized every 20 minutes
# Combivent Respimat®	1 inhalation 4 times a day
# Other	

Triggers

Check all items that trigger patient's asthma:

- ☐ Colds/flu
- ☐ Exercise
- ☐ Allergens
 - ☐ Dust Mites, dust, stuffed animals, carpet
 - ☐ Pollen - trees, grass, weeds
 - ☐ Mold
 - ☐ Pets - animal dander
 - ☐ Pests - rodents, cockroaches
- ☐ Odors (Irritants)
 - ☐ Cigarette smoke & second hand smoke
 - ☐ Perfumes, cleaning products, scented products
 - ☐ Smoke from burning wood, inside or outside
- ☐ Weather
 - ☐ Sudden temperature change
 - ☐ Extreme weather - hot and cold
 - ☐ Ozone alert days
- ☐ Foods:
 - ☐ _____
 - ☐ _____
 - ☐ _____
 - ☐ _____
- ☐ Other:
 - ☐ _____
 - ☐ _____
 - ☐ _____
 - ☐ _____

This asthma treatment plan is meant to assist, not replace, the clinical decision-making required to meet individual patient needs.

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Permission to Self-administer Medication:

- # This student is capable and has been instructed in the proper method of self-administering of the non-nebulized inhaled medications named above in accordance with NJ Law.
- # This student is not approved to self-medicate.

PHYSICIAN/APN/PA SIGNATURE _____ DATE _____

Physician's Orders

PARENT/GUARDIAN SIGNATURE _____

PHYSICIAN STAMP

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