Asthma Treatment Plan – Student

(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
☐ 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	☐ 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 Peak flow 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.

Disclaimers: [illegible]

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 date of birth
   - Child's doctor's name & phone number
   - 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
   - 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

PACNJ
Pediatric/Adult Asthma Coalition

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THE WARDLAW+HARTRIDGE SCHOOL School Year 20___ - 20___

PARENT/GUARDIAN PERMISSION FOR MINOR STUDENT TO SELF-ADMINISTER MEDICATION

I, the parent/guardian of ____ authorize my child, a pupil at The Wardlaw+Hartridge School to self-administer medication prescribed by our physician as described below for a life-threatening condition. Such Medication is generally limited to Asthma Inhaler, pre-filled Epinephrine auto-injector with or without a unit dose of Benadryl, and Diabetic Care/Medications. I understand that this permission is valid only for this school year and must be renewed for each school year, should my child's condition require it. I further understand that neither The Wardlaw+Hartridge School employees or nurse, and/or ESCNJ's employees or nurse shall be responsible for any liability as a result of any injury arising from the selfadministration of this medication by my child, or misuse of the medication. I agree that this information will be shared on a need to know basis with school personnel. All medications must be non-expired and be brought to school in an original, unopened labeled pharmacy container, including for over-the-counter medications.

Parent/Guardian Signature __________________print name___________________Date______________

(*See other side****) 2-sided document 18 and over must sign this form**

PHYSICIAN'S AUTHORIZATION/ASSURANCE STATEMENT FOR STUDENT'S SELF-ADMINISTRATION OF MEDICATION I certify that _________________________is under my care for a life-threatening condition. I am recommending that the above-named student be permitted to self-administer medication. He/She is capable of, and has been instructed by me in the proper method of self-administration of the following medications: (Such medication is generally limited to Asthma Inhaler, pre-filled Epinephrine autoinjector with or without a unit dose of Benadryl, and IDDM meds)

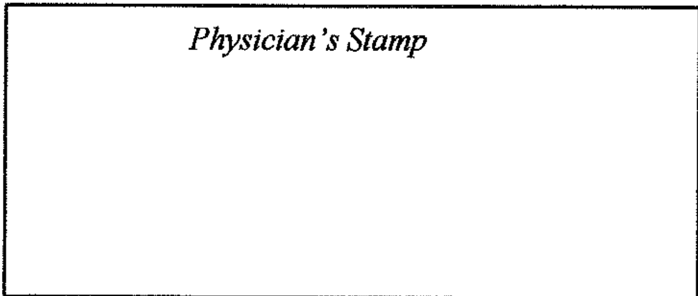
Name and Purpose of Medication: ____

Identification of life-threatening medical problems: ____

Prescribed dosage/route/schedule: ____

Length of time medication to be taken: ____

Possible side effects and/or special precautions: ____



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Prescribing Physician's Signature

____

Please print name and address of Prescribing Physician

____

Telephone # date

NEITHER THE WARDLAW+HARTRIDGE SCHOOL NOR ANY EMPLOYEE OR NURSE, NURSE'S AGENTS/EMPLOYER, ESCNJ NURSE(S) SHALL BE RESPONSIBLE FOR ANY LIABILITY AS A RESULT OF ANY INJURY TO THE ABOVE-NAMED STUDENT, ARISING FROM THE SELFADMINISTRATION OF MEDICATION OR ANY MISUSE OF THE MEDICATION.

Parent Form (see other side; 2-sided document**)**

Self-Administration Policy & Release

Students who self-administer must be authorized to do so **in writing** by their doctor and parent, and as approved by school nurse. See school nurse for forms. "Self-Administrators" are responsible to carry and self-administer their approved medications **with them at all times.** This includes before, during, and after school, as well as **any and all** school functions, performances, trips, clubs, activities, or sports events. The medication(s) the student's doctor orders must be sent with the student daily **from home.** As a parent, you agree to oversee that your student has the **appropriate, un-expired, properly pharmacy labeled** medications with them daily. Parent agrees to share this policy, review this policy with your child. Student and parent agree not to share his/her medications with anyone. Furthermore, all agree the student will tell the person in charge of the school event they have taken medication. The school nurse should also be informed when available. Student must seek adult help immediately at any time he/she needs to, or if there is a problem or concern, as well as seek out school nurse with questions.

We agree to indemnify and hold harmless the Wardlaw+Hartridge School, its employees/agents; and school nurse/nurse's employer(s), ESCNJ's employees/nurse(s) from any claims arising from failure of parent or student following this policy/procedure.

I understand and have instructed my child, along with his or her doctor's guidance, in proper use, storage, and administration of the prescribed medication(s). I will only send in the prescribed amount needed.

Self-administrators are also required to keep a "back-up" set of medications in the nurse's office for emergency use (while still carrying a set of their "own" medications with them daily).

Student Name ___________________________________

Parent/Guardian print name_________________________

Parent/Guardian signature__________________________

THE WARDLAW+HARTRIDGE SCHOOL AUTHORIZATION FOR MEDICATION IN SCHOOL

The following section is to be completed by the **PARENT**: School Year: 20__ - 20__

Child's Name:____________________________ *Date of birth:*_______________ *grade:*________

I request that my child be assisted in taking the medicine described below at school by authorized persons. The medication prescribed below is needed during school hours for my child to properly function and cannot be given at home. Herbal and dietary supplements are not considered medications and cannot be given in school. All medication must be **brought to school by a parent/guardian**, **in an original unopened labeled pharmacy container**, including for over-the-counter medications also. Please check and note expiration date. At the conclusion of treatment/school year (whichever is first) parent/guardian **must pick up** medication or it will be **discarded** on the last day of school. Changes to regime must be put in writing by prescribing physician. I agree that information may be shared with appropriate school personnel on a need to know basis. Neither the Wardlaw+Hartridge School employees or school nurse, and/or the Educational Services Commission of NJ's employees or nurse shall be responsible for any liability as a result of any injury arising from the authorized administration of medication.

__________ ______________________________ ____________________________________

Date PRINT NAME parent/guardian Parent/Guardian Signature

Student s 18 and over must sign form themselves

The following section is to be completed by the **PHYSICIAN**:

Child's name:________________________ DOB:__________________ Diagnosis:______________

Medication: _________________________Dosage: __________________ Route: _______________

If medicine is to be given daily, at what time? ____

If medicine is to be given "when needed," describe indications: __________________________________

How soon can it be repeated? ____

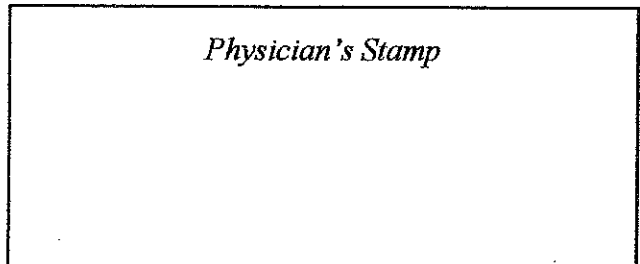
Length of time this treatment is recommended: ____

Print Physician's Name: _____________________

Signature of physician: _____________________

Address/telephone number____________________

Date: ___________________________________


Physician's Stamp