Asthma Treatment Plan – Student

(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
D Advair® HFA D 45, D 115, D 230 _	2 puffs twice a day
D Aerospan™ _	D 1, D 2 puffs twice a day
D Alvesco® D 80, D 160 _	D 1, D 2 puffs twice a day
D Dulera® D 100, D 200 _	2 puffs twice a day
D Flovent® D 44, D 110, D 220 _	2 puffs twice a day
D Qvar® D 40, D 80 _	D 1, D 2 puffs twice a day
D Symbicort® D 80, D 160 _	D 1, D 2 puffs twice a day
D Advair Diskus® D 100, D 250, D 500 _	1 inhalation twice a day
D Asmanex® Twisthaler® D 110, D 220 _____	D 1, D 2 inhalations D once or D twice a day
D Flovent® Diskus® D 50 D 100 D 250 _	1 inhalation twice a day
D Pulmicort Flexhaler® D 90, D 180 _____	D 1, D 2 inhalations D once or D twice a day
D Pulmicort Respules® (Budesonide) D 0.25, D 0.5, D 1.0	1 unit nebulized D once or D twice a day
D Singulair® (Montelukast) D 4, D 5, D 10 mg _	1 tablet daily
D Other	
D 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
D Albuterol MDI (Pro-air® or Proventil® or Ventolin®) _	2 puffs every 4 hours as needed
D Xopenex®	2 puffs every 4 hours as needed
D Albuterol D 1.25, D 2.5 mg	1 unit nebulized every 4 hours as needed
D Duoneb®	1 unit nebulized every 4 hours as needed
D Xopenex® (Levalbuterol) D 0.31, D 0.63, D 1.25 mg _	1 unit nebulized every 4 hours as needed
D Combivent Respimat®	1 inhalation 4 times a day
D Increase the dose of, or add:	
D Other	

- **If quick-relief medicine is needed more than 2 times a week, except before exercise, then call your doctor.**

Emergency (Red Zone)

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
D Albuterol MDI (Pro-air® or Proventil® or Ventolin®) _	4 puffs every 20 minutes
D Xopenex®	4 puffs every 20 minutes
D Albuterol D 1.25, D 2.5 mg	1 unit nebulized every 20 minutes
D Duoneb®	1 unit nebulized every 20 minutes
D Xopenex® (Levalbuterol) D 0.31, D 0.63, D 1.25 mg	1 unit nebulized every 20 minutes
D Combivent Respimat®	1 inhalation 4 times a day
D 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.

REVISED MAY 2017

Permission to Self-administer Medication:

D 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 P.A. Law.

D 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 **PA 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:**
  - v **Write in asthma medications not listed on the form**
  - v **Write in additional medications that will control your asthma**
  - v **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

D I do request that my child be **ALLOWED** to carry the following medication - for self-administration in school pursuant to **P.A. Code 14-1414.1**. 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.

D I **DO NOT** request that my child self-administer his/her asthma medication.

Parent/Guardian Signature _____ Phone _____ Date _____