Asthma Treatment Plan – Student

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

PACNJ Pediatric/Adult Asthma Coalition — Sponsored by American Lung Association in New Jersey — NJ Health New Jersey Department of Health

(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.

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REVISED MAY 2017

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 _____

PACNJ Pediatric/Adult Asthma Coalition

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Sponsored by
AMERICAN LUNG ASSOCIATION. IN NEW JERSEY

PATERSON PUBLIC SCHOOL

ACTIVITY LIMITATION FORM

PS#: _____ **(973) 321-** _____ **DATE GIVEN:** _____ **DATE RETURNED:** _____

STUDENT: _____ **DOB:** _____ **GRADE/HR:** _____

Dear Doctor:
Our records indicate that the above named student requires an individual activity plan. Please provide a diagnosis and what accommodations, if any, are needed. Will you kindly check below the activities that the student may participate in?

PROGRAM OF FULL PARTICIPATION:

_____ **YES** _____ **NO**

Relating *to* ***DIAGNOSIS***: _____

Student **MAY PARTICIPATE FULLY** in the school program **WITHOUT RESTRICTIONS**.

PHYSICIAN PRINT/ STAMP: _____ **PHONE:** _____

PHYSICIAN SIGNATURE: _____

OR:

PROGRAM OF RESTRICTED ACTIVITY:

Start date: _____ **End Date:** _____

Relating to **DIAGNOSISI:** _____, *the following plan is indicated.*

Student **MAY PARTICIPATE** in the following activities:	**YES**	**NO**
WARM-UP EXERCISES: Stretching , walking		
LOW IMPACT AEROBICS: Jumping, hopping, jogging, dance, Tae Bo		
SWIMMING:		
STUNTS: Tumbling, rolling, balance, strength		
PHYSICAL FITNESS TESTING: Running, sit-ups, push-ups, pull-ups		
NON-CONTACT GAMES: Paddle ball, jump rope, badminton, tennis, bowling, other racket sports		
WEIGHT TRAINING PROGRAM: Free weights, treadmill		
TRACK AND FIELD: Sprints, intermediate & distance running, long jump, high jump, shot-put		
APPARATUS: Climbing, vaulting, support, suspension		
COMPETATTIVE GAMES: Soccer, hockey, basketball, baseball, softball, whiffleball, volleyball, speedball, touch football		
RECESS PLAY:		

STAIR CLIMBING (Circle) : **YES** **NO** * Number of flights of stairs allowed per day _____

USE OF HELMET in gym: **YES** **NO** in recess: **YES** **NO** in class: **YES** **NO**

OTHER PROTECTIVE ***and*****/or ASSISTIVE DEVICES** ***(please specify):*** _____

OTHER RESTRICTIONS: _____

PHYSICIAN PRINT /STAMP _____ **PHONE:** _____

PHYSICIAN SIGNATURE _____ **DATE:** _____

_____ INITIAL EXAM _____ ANNUAL FOLLOW UP

Approved by School Physician: _____ **Date:** _____

INDIVIDUALIZED HEALTHCARE PLAN (IHP)
ASTHMA

STUDENT NAME:_____**DOB**_____

Student Address:
Home Phone:
Parent/Guardian:
Day/Work Phone:
Healthcare Provider:
Provider Phone:
IHP Written By:

School:
Teacher/Counselor:
Grade:
IHP Date:
IEP Date:
Review Date(s):
ICD-9 Codes:

Parental/Guardian statement: ***I/We have read this plan and agree to its implementation.***
Signature:_____**Date:**_____

Assessment Data	Nursing Diagnosis	Goals	Nursing Interventions	Expected Outcome
	Ineffective airway clearance associated with chronic inflammation causing bronchoconstriction and excessive mucus production.	The student will assist in the development of an Asthma Action Plan with the parent and healthcare provider. The student will have his/her needed asthma medication available and easily accessible at school. The student will increase his/her ability to identify and manage environmental triggers.	Obtain an Asthma Action Plan from the parents/guardians and the healthcare provider. Identify the student's level of asthma severity by monitoring peak flows and asthma signs and symptoms to help in establishing priority for intervention. Ensure that quick-relief medication is easily and quickly available to the student	The student will have an Asthma Action Plan on file in the school health office to be used in developing an IHP and ECP. The student will demonstrate proper technique for using asthma medications and medication. delivery devices The student will assist in making sure that necessary medication is easily accessible and available.

STUDENT NAME: _____ **DOB** _____

Parental/Guardian Statement: ***I/We have read this plan and agree to its implementation.***

Signature:_____ **Date:** _____

Assessment Data	Nursing Diagnosis	Goals	Nursing Interventions	Expected Outcomes
	Deficient knowledge about asthma and asthma self-care	The student will increase his/her knowledge about asthma and skills in asthma self-management, including the importance of adherence to the Asthma Action Plan and IHP to avoid asthma episodes and possible long-term harm to airways.	Educate teachers and other school personnel about the student's asthma, monitoring of student's symptoms, and means to implement the asthma management plan. Educate the student and family about: -characteristics of good control of asthma; -early recognition of signs and symptoms of an asthma exacerbation, interpretation of peak flow meter results, and actions to take to manage asthma symptoms; -student's asthma triggers and specific strategies to avoid or control exposure to -rights and responsibilities for self-carrying of inhaler medication	The student will identify symptoms of asthma. The student will identify early indications of an asthma exacerbation. The student will identify his/her asthma triggers and list strategies for how to avoid these or how to control exposure to them. The student will identify and describe responsibilities for self-carrying of medication and demonstrate safe use of self-carry medications. The student will periodically review with the school nurse and parent the effectiveness of his/her asthma management.

HEALTH OFFICE

School #24/Fine and Performing Arts Program

Grade_____ Home #_____

Student's Name_____

Mother's Name_____

Father's Name_____

Address_____

City_____

Home Phone #_____

Mother's Cell #_____

Father's Cell #_____

Parent Signature _____

EMERGENCY CONTACT NUMBERS TO FOLLOW:

1. Name_____

   Relation_____

   Emergency # _____

2. Name_____

   Relation_____

   Emergency # _____

3. Name_____

   Relation_____

   Emergency # _____

PATERSON PUBLIC SCHOOLS DISTRICT
90 DELAWARE AVENUE
PATERSON, NEW JERSEY 07503

DEPARTMENT OF NURSING SERVICES

Date:_____

Name and Address of School Nurse and Public School:

_____

_____

_____

To Whom It May Concern:

This is to certify that I,_____ the

Parent/Legal Guardian of _____ Grade_____, do

hereby give my written consent for you to release or obtain any medical records that you might have in your possession concerning_____ DOB_____

Please send records to the attention of the Hospital or Health Care Provider at:

Health Care Provider Address →_____

_____

_____

Signature of
Parent or Guardian:_____

Signature of
Health Care Provider:_____Telephone #:_____

Signature of
School Nurse:_____Telephone #:_____

PATERSON PUBLIC SCHOOLS DISTRICT
90 DELAWARE AVENUE
PATERSON, NEW JERSEY 07503

DEPARTMENT OF NURSING SERVICES

Parent/Guardian Permission to Release and Exchange Confidential Health Information

Student Name: _____ **DOB:** _____

Address: _____ **Student ID#**_____

To Whom It May Concern:

This is to certify that I,_____, the parent/legal guardian of _____, hereby authorize an exchange of information regarding my child, _____, to occur between the school and staff members who interact with_____.

This information may also be shared with the Intervention and Referral Service Team, Child Study Team, and /or the 504 Team if needed.

This authorization is in effect for the School Year: _____

Parent/Guardian Name (Print): _____
Parent/Guardiain Signature: _____ **Date:** _____
School Nurse: _____ Telephone Number: _____

PATERSON PUBLIC SCHOOLS DISTRICT
90 DELAWARE AVENUE
PATERSON, NEW JERSEY 07503

NURSING SERVICES

Date_____

Name and Address of Hospital or Health Care Provider:

_____

_____

_____

To Whom It May Concern:

This is to certify that I, _____, the
(Parent/Guardian Name)
parent / legal guardian of _____ Grade _____, do
(Student Name)
hereby give my written consent for you to release or obtain any medical records that you might have in your possession concerning _____ DOB_____.
(Student Name)

Please send records to the attention of the School Nurse at:

School Name and Address → _____

_____

_____

Signature of
Parent or Guardian: _____

Signature of
School Nurse: _____ Telephone # 973-321-___ ___ ___

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