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.

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

REVISED MAY 2017

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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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 DIAGNOSIS: _____, **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, Zumba		
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: springs, intermediate & distance running, long jump, high jump, shot-put		
APPARATUS: climbing, vaulting, support, suspension		
COMPETITIVE GAMES: soccer, hockey, basketball, baseball, softball, 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:** _____

Paterson Public Schools
New Roberto Clemente/Newcomers @ NRC
482-506 Market Street, Paterson, NJ 07501
School Health Office
Telephone: 973-321-0249
Fax: 973-321-0247

Grade _____ Homeroom # _____

Student Name: _____

Mother's Name: _____

Father's Name: _____

Address: _____

City: _____

Home Phone #: _____

Mother Cell # _____

Father Cell #: _____

Parent Signature: _____

Emergency contact numbers to follow:

1. Name: _____
   Relation: _____
   Emergency #: _____

2. Name: _____
   Relation: _____
   Emergency #: _____

3. Name: _____
   Relation: _____
   Emergency #: _____

PATERSON PUBLIC SCHOOLS

Department of Nursing Services
90 Delaware Avenue, Paterson NJ 07503
Office: (973) 321-0722 Fax: (973) 321-0485

Date: _____

Name and Address of Hospital or Health Care Provider:

_____

_____

_____

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 School Nurse at:

School Name and Address _____

_____

_____

Signature of Parent or Guardian: _____

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

PATERSON PUBLIC SCHOOLS

Department of Nursing Services
90 Delaware Avenue, Paterson NJ 07503
Office: (973) 321-0722 Fax: (973) 321-0485

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 Healthcare Provider: _____ Telephone: _____

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

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.

Asthma Emergency Plan

Name: _____ DOB: _____ School Year: _____

Student ID: _____ Teacher/Grade: _____ Date: _____

Parent: _____ Phone: _____ Nurse: _____

Alternate Parent: _____ Phone: _____

Doctor: _____ Phone: _____

If this student complains of asthma symptoms: shortness of breath, wheezing, chest tightness, coughing, "can't get air", etc. the student will let you know.

The Doctor and parent has allowed this student to self-medicate for asthma symptoms in school and on field trips. Please keep this information in your sub folder as well as your emergency book.

The student will take the following medication:

_____ Albuterol (Ventolin, Pro-Air, Proventil) pump is taken 2 puffs by mouth every 4 hours as needed OR other medication _____

The student will follow this procedure: (a spacer may be attached to the pump)

"Shake it, shake it, but don't break it!"

Take a deep breath and let it out.

Place the pump in mouth with lips closed around pump.

Press the pump firmly while inhaling the medicine; hold breath for 10 seconds.

Take the pump out of mouth; count 60 seconds and repeat the procedure.

The medicine takes about 15 minutes to work, if symptoms get worse or student does not feel better, child can take medicine every 20 minutes. Call 9-1-1 if symptoms do not improve after the second set of medication.

If there is an evacuation, student will evacuate with the teacher to the new location.