Asthma Treatment Plan — Student Plan — Student AMERICAN (This asthma action plan meets NJ Law N.J.S.A. 18A:40-12.8) (Physician's Orders)







Please Pr	int)			remark/Audur	Asthma Coalition 114 May page	<u> </u>
Name		ŶΞ		Date of Birth	Effective Date	·
Doctor			Parent/Guardian (if app	icable)	Emergency Contact	
Phone			Phone		Phone	
			ake daily confre) life	edicine(s). Son	ne intraters may be it	Triggers
HEALIHY	(Green Zone)		nore effective with a			Check all items
	You have all of the	ese: ME	DICINE	HOW MUCH to take	e and HOW OFTEN to take it	that trigger patient's asthma:
130	 Breathing is good 	10	Advair® HFA □ 45. □ 115. □ 23	0 2 put	ffs twice a day	Colds/flu
2	• No cough or wheeze		Aerospan™Alvesco® □ 80, □ 160	<u></u>	☐ 2 puffs twice a day	□ Exercise
27.5	• Sleep through	님	ANGSCO®	i 1, 2 nut	L∐ 2 puπs twice a day ffs twice a day	□ Allergens
3	the night	١Ä	Dulera®	2 put	ffs twice a day	O Dust Mites,
	• Can work, exercise,		Qvar® 🗆 40, 🗀 80		☐ 2 puffs twice a day	dust, stuffed animals, carpet
	and play		Symbicort®		☐ 2 puffs twice a day ☐ 2 puffs twice a day alation twice a day ☐ 2 inhalitions ☐ once or ☐ twice a day	o Pollen - trees,
		님	AGVAIT DISKUS® 📋 100, 📋 250, 🗀 Asmaney® Twisthaler® 🗀 110 🗀	220I IIII	ialation (wice a day □ 2 inhalations □ once or □ (wice a da)	grass, weeds
A			PIOVENT & DISKUS TO DO TO LOG F	1 มกก	ialation twice a day	a Data animal
	- 12 P		Pulmicort Flexhaler® ☐ 90, ☐ 18	30	, □ 2 inhalations □ once or □ twice a da it nebulized □ once or □ twice a day	O Pets - animal dander
		님	Pulmicort Respules® (Budesonide) 🔲 U Singulair® (Montelukast) 🔲 4, 🔲 5,	.25, □ 0.5, □ 1.01 uni	it nebulized [] once of [] twice a day	O TOWN TOUCHER
5.3			Other	rang ran	Het dany	cockroaches
And/or Peak	flow above	1=	None			Odors (Irritants) Cigarette smok
, , , , , , , , , , , , , , , , , , , ,	9 570	12000	Remember	to rinse your mou	th after taking inhaled medicin	& second hand
	if exercise trigge	ers your a			(s)minutes before exercise	
		1 900	er in del como de la final de	Wasanthae Chichara (1900)	PROPERTY AND ADMINISTRATION OF THE PROPERTY OF	cleaning
CAUTION	(Yellow Zone)		Continue daily captrol de	edicine(s) and Al	D quick-relief medicine(s).	products, scented
	You have any of t	hese:	EDICINE	HOW MICH to tal	ke and HOW OFTEN to take it	products
900	• Cough				- 	 Smoke from burning wood,
(2)	 Mild wheeze 		Albuterol MDI (Pro-air® or Prove			inside or outside
	 Tight chest 				puffs every 4 hours as needed	□ Weather
1	 Coughing at night 	1 -	Duoneb®	'	unit nebulized every 4 hours as needed unit nebulized every 4 hours as needed	O Sudden
COM	• Other:				unit nebulized every 4 hours as meeded	
SO		l n	Combivent Respirat®			 Extreme weath
	medicine does not help w	1011111 —	Increase the dose of, or add:			 hot and cold Ozone alert day
	or has been used more t	uiaii _	Other	820		G 620the alert day
	mptorms persist, call you the ernergency room.	' <u>•</u>	If quick-relief medic	ine is needed	more than 2 times a	0
_	flow fromto		week, except before			0
						≓∘
EMERGE	NCY (Red Zone)				DW and CALL 911.	
900	Your asthma is		Asthma can be a lif	e-threatening	illness. Do not wait!	°
	getting worse fa Quick-relief medici		MEDICINE	HOW MUC	H to take and HOW OFTEN to take	it 0
	not help within 15-		☐ Albuterol MDI (Pro-air® or P	roventil® or Ventolin®)	4 puffs every 20 minutes	
	 Breathing is hard of 	or fast	Xopenex®		4 puffs every 20 minutes	This asthma treatmen
• Nose opens wide • Ribs show			☐ Xopenex® 4 puffs every 20 minutes W ☐ Albuterol ☐ 1.25, ☐ 2.5 mg 1 unit nebulized every 20 minutes			plan is meant to assis
	 Trouble walking an Lips blue • Fingeri 		☐ Duoneb®1 unit nebulized every 20 minutes ☐ Xopenex® (Levalbuterol) ☐ 0.31, ☐ 0.63, ☐ 1.25 mg1 unit nebulized every 20 minutes			not replace, the clinic decision-making
And/or Peak flow	• Other:	IZIIS DIUG	☐ Combivent Respimat®		1 inhalation 4 times a day	required to meet
below	<u> </u>	•	☐ Other			individual patient nee
	Name and American Street of the contract of th		0	1 -		
padde yn yr 'm ly' mae fly Apadia Cyflaid ei llyr Aragy ac di o'ffafer fly Labelle fly andres apadean market	PACE Interm Terminal Proof & Collect in 6 per not oil. The course is to be about the ST of the Low Assembly of the ST of the	Permissio	n to Self-administer Medication:	PHYSICIAN/APN/PA S	SIGNATURE	DATE
the state of the s	ner en er en		dent is capable and has been instructed		Physician's Orders	
	rgiger originiyang. Traggan Par ababar tapap an ayung antapa, bal a pilik ap glandar tar progisik of aya gianga. Abib di pal balikan se program unidada of ita balan Tagamar Pan, ay of tila salaha		oper method of self-administering of the		SIGNATURE	
Name and Administration	أحاطان كالصنانة والمساة ويترجيدها ويوسي	tion-ned	ulized inhaled medications named above	1	·······	

Make a copy for parent and for physician file, send original to school nurse or child care provider.

This student is <u>not</u> approved to self-medicate.

PHYSICIAN STAMP

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

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



- . 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
 - <u>Permission to Self-administer Medication</u> 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.							
DO NOT request that my child self-administer his/her asthma medication.							
Parent/Guardian Signature	Phone	Date					



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