

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
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ASSOCIATION**

NJ Health



(Please Print)

Name		Date of Birth	Effective Date
Doctor	Parent/Guardian (If applicable)		Emergency Contact
Phone	Phone		Phone

HEALTHY (Green Zone) IIIII



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
☐ Aerospir™	☐ 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, ☐ 600	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) IIIII



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) IIIII



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 _____

Physician's Orders

DATE _____

PARENT/GUARDIAN SIGNATURE _____

PHYSICIAN STAMP

Revised May 2017
Permission to reproduce blank form - www.pacnj.org

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

Note : For Field Trips Please indicate if the student is able to Self-Administer Inhaler

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

- ### PARENT AUTHORIZATION

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

[illegible]

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:

Relating to **DIAGNOSIS**: _____ YES _____ NO

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

PHYSICIAN PRINT/ STAMP: _____ PHONE: _____
 PHYSICIAN SIGNATURE: _____

OR:

PROGRAM OF RESTRICTED ACTIVITY:

Relating to **DIAGNOSIS**: _____ Start date: _____ End Date: _____
 Student **MAY PARTICIPATE** in the following activities: _____, the following plan is indicated.

	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: Sprints, 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: _____

Asthma Individualized Healthcare Plan



Student _____ DOB _____

School _____ Grade _____

IHP Effective Dates ____/____/____ to ____/____/____

Medical Home _____

Phone # _____

Parent/Guardian _____

Home# _____ Cell# _____ Work# _____

Emergency Contact _____

Phone# _____

School Nurse Signature _____ Date _____

Parent Signature _____ Date _____

Purpose of the IHP: to meet the student healthcare needs during the school day

Nursing Diagnosis or Concerns:

- Potential for alteration in breathing pattern/gas exchange related to bronchospasm or inflammation of the airways/increased mucus production.
- Potential for alteration in activity tolerance related to asthma
- Potential for self-care deficit related to knowledge deficit about asthma and asthma

Asthma Individualized Healthcare Plan



- management measures.
- Potential for alteration in role performance related to absence from school/class due to asthma symptoms.

Goals:

- Attain and maintain near normal pulmonary function.
- Prevention of asthma symptoms, such as chronic cough and difficulty breathing.
- Develop and implement an Asthma Action Plan.
- Participate in regular school/class activities, including physical education, with modifications made if necessary.
- Increase knowledge of his/her asthma.
- Develop asthma self-care skills.
- Compliance with prescribed asthma management plan.

Nursing Interventions:

- Develop and implement Asthma Action Plan
- Obtain medication orders and authorization for any asthma medications needed at school (parent and medical home).
- Keep accurate records of asthma episodes.
- In-service teachers and other appropriate school staff.
- Assist physical education teachers to modify physical education requirements, if necessary.
- Assist parents/guardians, teachers and healthcare providers in understanding the student's need to participate in regular classroom activities and discuss modifications that may be needed.
- Provide information to parents about when it is appropriate and not appropriate to send their child to school, based on specific symptoms.
- Assist the student to administer prescribed medications (dependent on the student's knowledge and skills).
- Monitor medication administration and reinforce proper technique as needed.
- Assist student to develop self-care skills
- Demonstrate proper technique for administering medications
- Demonstrate proper abdominal breathing techniques; require repeat demonstration.
- Demonstrate proper use of peak flow meter; require repeat demonstration.
- Discuss how to recognize early warning signs of an asthma episode and what to do if any of those signs occur.



Charles J. Riley School 9 Health Office
6 Timothy Street
Paterson, NJ, 07503
Phone (973) 321-0099 Fax (973) 321-0098
Email: nasfour@paterson.k12.nj.us

Domenico Carriero, Principal
dcarriero@paterson.k12.nj.us

Kenneth Garra-brant, Vice-Principal
kgarra-brant@paterson.k12.nj.us
Elenh Andreanidis, Vice-Principal
eandrianidis@paterson.k12.nj.us

Parent/ Guardian Permission to Release and Exchange Confidential Health Information

I _____ the parent/guardian of _____
Hereby authorize the exchange of any information regarding my child to occur between
the school nurse and staff members who participate in my child's care while they are in
school.

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

This authorization is in effect for School Year _____

Parent/Guardian Name _____

Parent/Guardian Signature _____

Date _____

School Nurse (Printed) _____

School Nurse Signature _____



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Domenico Carriero, Principal
dcarriero@paterson.k12.nj.us

Kenneth Garrabrant, Vice-Principal
kgarrabrant@paterson.k12.nj.us
Elenh Andreanidis, Vice-Principal
eandrianidis@paterson.k12.nj.us

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 share information and/or release 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 Nurse's Name : Namaty Asfour-Darwish, RN, BSN, CSN
School Name and address : Charles J. Riley School 9
6 Timothy Street
Paterson, NJ, 07503

Signature of Parent or Guardian: _____

Signature of School Nurse: _____