Asthma Treatment Plan – Student

(Please Print)

Name ________________________________ Date of Birth ____________________ Effective Date ____________________

Doctor ________________________________ Parent/Guardian (if applicable) ________________ Emergency Contact ________________

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

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 ______

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 from ______ to ______

Take daily control medicine(s). Some inhalers may be more effective with a “spacer” – use if directed.

<table>
<thead>
<tr>
<th>MEDICINE</th>
<th>HOW MUCH to take and HOW OFTEN to take it</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advair® HFA</td>
<td>45, 115, 230 2 puffs twice a day</td>
</tr>
<tr>
<td>Alvesco®</td>
<td>80, 160 1, 2 puffs twice a day</td>
</tr>
<tr>
<td>Dulera®</td>
<td>100, 200 2 puffs twice a day</td>
</tr>
<tr>
<td>Flovent®</td>
<td>44, 110, 220 2 puffs twice a day</td>
</tr>
<tr>
<td>Qvar®</td>
<td>40, 80 1, 2 puffs twice a day</td>
</tr>
<tr>
<td>Symbicort®</td>
<td>80, 160 1, 2 puffs twice a day</td>
</tr>
<tr>
<td>Advair Diskus®</td>
<td>100, 250, 500 1 inhalation twice a day</td>
</tr>
<tr>
<td>Asmanex® Twi thal®</td>
<td>110, 220 1, 2 inhalations once or twice a day</td>
</tr>
<tr>
<td>Flovent® Diskus®</td>
<td>50, 100 1, 250 1 inhalation twice a day</td>
</tr>
<tr>
<td>Pulmicort Flexhaler®</td>
<td>90, 180 1, 2 inhalations once or twice a day</td>
</tr>
<tr>
<td>Pulmicort Respules® (Budesonide)</td>
<td>0.25, 0.5, 1.0 1 unit nebulized once or twice a day</td>
</tr>
<tr>
<td>Singularair® (Montelukast)</td>
<td>4, 5, 10 mg 1 tablet daily</td>
</tr>
<tr>
<td>Other</td>
<td>None</td>
</tr>
</tbody>
</table>

And/or Peak flow above ______

Remember to rinse your mouth after taking inhaled medicine.

If exercise triggers your asthma, take this medicine ______ minutes before exercise.

Take these medicines NOW and CALL 911. Asthma can be a life-threatening illness. Do not wait!

<table>
<thead>
<tr>
<th>MEDICINE</th>
<th>HOW MUCH to take and HOW OFTEN to take it</th>
</tr>
</thead>
<tbody>
<tr>
<td>Combinvent®</td>
<td>Maxair® Xopenex® 2 puffs every 4 hours as needed</td>
</tr>
<tr>
<td>Ventolin®</td>
<td>Pro-Air® 1, 2 puffs every 4 hours as needed</td>
</tr>
<tr>
<td>Albuterol</td>
<td>1.25, 2.5 mg 1 unit nebulized every 4 hours as needed</td>
</tr>
<tr>
<td>Duoneb®</td>
<td>0.31, 0.63, 1.25 mg 1 unit nebulized every 4 hours as needed</td>
</tr>
<tr>
<td>Xopenex® (Leval buterol)</td>
<td>0.25, 0.5, 1.0, 2.5 mg 1 unit nebulized every 4 hours as needed</td>
</tr>
<tr>
<td>Other</td>
<td>Increase the dose of, or add:</td>
</tr>
</tbody>
</table>

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

Permissions and Other Information:

- 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 __________

PARENT/GUARDIAN SIGNATURE ____________________

PHYSICIAN STAMP ____________________

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

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 - roidants, 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:
  - __________
  - __________
  - __________
  - __________
  - __________
  - __________

This asthma treatment plan is meant to assist, not replace, the clinical decision-making required to meet individual patient needs.

Revision August 2013

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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

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