Asthma Treatment Plan – Student

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

The Pediatric/Adult Asthma Coalition)of New Jersey





(Please Print)					
Name	[[Date of Birth	Effective Date		
Doctor	Parent/Guardian (if applie	cable)	Emergency Contact		
Phone	Phone		Phone	······································	
HEALTHY (Green Zone)	Take daily control me more effective with a MEDICINE	"spacer" – use i	inhalers may be directed.	Triggers Check all items that trigger patient's asthma:	
• Sleep through	Advair® HFA 45, 115, 230 Aerospan™ 160 160 100, 200 160 100, 200 100, 220 100, 220 100, 250, 250, 250	2 putfs tw	ice a day puffs twice a day puffs twice a day ice a day ice a day puffs twice a day puffs twice a day puffs twice a day on twice a day ontwice a day ontwice a day ontwice a day	Colds/flu Distercise Distingens Dist Mites, dust, stuffed animals, carpet Oilen - trees, grass, weeds Distingens	
And/or Peak flow above	☐ Singulair® (Montelukast) ☐ 4, ☐ 5, ☐ Other☐ None Remember :	to rinse your mouth a	ally Iter taking inhaled medicine minutes before exercise.	Smort	
CAUTION (Yellow Zone) HIE>	Continue daily control me			o Perfumes, cleaning products scented	
You have <u>any</u> of these: Cough Mild wheeze Tight chest Coughing at night Other:	☐ Albuterol ☐ 1,25, ☐ 2.5 mg	ntil® or Ventolin®) _2 puffs 2 puffs 1 unit i 1 unit i	every 4 hours as needed nebulized every 4 hours as needed nebulized every 4 hours as needed	temperature change	
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 fromto	☐ Combivent Respirat®☐☐ ☐ Increase the dose of, or add:☐☐ Other ■ If quick-relief medicion week, except before	i inhal ne is needed mo	ation 4 times a day re than 2 times a	O Extreme weather - hot and cold O Ozone alert days D Foods: O	
EMERGENCY (Red Zone) Your asthma is getting worse fast:	Asthma can be a life	e-threatening illu		O Other:	
- Quick-relief medicine did not help within 15-20 minu - Breathing is hard or fast - Nose opens wide - Ribs sh - Trouble walking and talkin - Lips blue - Fingernails blue - Other:	☐ Xopenex® 4 puffs every 20 minutes W☐ Albuterol ☐ 1.25, ☐ 2.5 mg 1 unit nebulized every 20 minutes			This asthma treatment plan is meant to assist, not replace, the clinical decision-making required to meet individual patient needs	
Edit State of the Property of the Control of the Co	ission to Seil-administer Medication: is student is capable and has been instructed the proper method of self-administering of the n-nebulized inhaled medications named above accordance with NJ Law.	PHYSICIAN/APN/PA SIGNAI	Physician's Orders	DATE	

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.

REVISED AUGUST 2014

PHYSICIAN STAMP

OVER

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

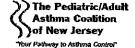
- · Child's doctor's name & phone number
- Parent/Guardian's name
- & phone number

- 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

· An Emergency Contact person's name & phone number

- · 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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