

Asthma Treatment Plan

(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**
"Your Pathway to Asthma Control"
PACNJ approved Plan available at
www.pacnj.org

Sponsored by
**AMERICAN
LUNG
ASSOCIATION.**
IN NEW JERSEY



(Please Print)

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

HEALTHY



Take daily medicine(s). Some metered dose inhalers may be more effective with a "spacer" - use if directed



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 _____

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
<input type="checkbox"/> Advair® <input type="checkbox"/> 100, <input type="checkbox"/> 250, <input type="checkbox"/> 500 _____	1 inhalation twice a day
<input type="checkbox"/> Advair® HFA <input type="checkbox"/> 45, <input type="checkbox"/> 115, <input type="checkbox"/> 230 _____	2 puffs MDI twice a day
<input type="checkbox"/> Alvesco® <input type="checkbox"/> 80, <input type="checkbox"/> 160 _____	<input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs MDI twice a day
<input type="checkbox"/> Asmanex® Twisthaler® <input type="checkbox"/> 110, <input type="checkbox"/> 220 _____	<input type="checkbox"/> 1, <input type="checkbox"/> 2 inhalations <input type="checkbox"/> once or <input type="checkbox"/> twice a day
<input type="checkbox"/> Flovent® <input type="checkbox"/> 44, <input type="checkbox"/> 110, <input type="checkbox"/> 220 _____	2 puffs MDI twice a day
<input type="checkbox"/> Flovent® Diskus® <input type="checkbox"/> 50 <input type="checkbox"/> 100 <input type="checkbox"/> 250 _____	1 inhalation twice a day
<input type="checkbox"/> Pulmicort Flexhaler® <input type="checkbox"/> 90, <input type="checkbox"/> 180 _____	<input type="checkbox"/> 1, <input type="checkbox"/> 2 inhalations <input type="checkbox"/> once or <input type="checkbox"/> twice a day
<input type="checkbox"/> Pulmicort Respules® <input type="checkbox"/> 0.25, <input type="checkbox"/> 0.5, <input type="checkbox"/> 1.0 _____	1 unit nebulized <input type="checkbox"/> once or <input type="checkbox"/> twice a day
<input type="checkbox"/> Qvar® <input type="checkbox"/> 40, <input type="checkbox"/> 80 _____	<input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs MDI twice a day
<input type="checkbox"/> Singulair <input type="checkbox"/> 4, <input type="checkbox"/> 5, <input type="checkbox"/> 10 mg _____	1 tablet daily
<input type="checkbox"/> Symbicort® <input type="checkbox"/> 80, <input type="checkbox"/> 160 _____	<input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs MDI twice a day
<input type="checkbox"/> Other _____	
<input type="checkbox"/> None	

Remember to rinse your mouth after taking inhaled medicine.

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

Triggers

Check all items that trigger patient's asthma:

- Chalk dust
- Cigarette Smoke & second hand smoke
- Colds/Flu
- Dust mites, dust, stuffed animals, carpet
- Exercise
- Mold
- Ozone alert days
- Pests - rodents & cockroaches
- Pets - animal dander
- Plants, flowers, cut grass, pollen
- Strong odors, perfumes, cleaning products, scented products
- Sudden temperature change
- Wood Smoke
- Foods:

Other: _____

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

CAUTION



Continue daily medicine(s) and add fast-acting medicine(s).



You have any of these:

- Exposure to known trigger
- Cough
- Mild wheeze
- Tight chest
- Coughing at night
- Other: _____

And/or Peak flow from _____ to _____

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
<input type="checkbox"/> Accuneb® <input type="checkbox"/> 0.63, <input type="checkbox"/> 1.25 mg _____	1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Albuterol <input type="checkbox"/> 1.25, <input type="checkbox"/> 2.5 mg _____	1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Albuterol <input type="checkbox"/> Pro-Air <input type="checkbox"/> Proventil® _____	2 puffs MDI every 4 hours as needed
<input type="checkbox"/> Ventolin® <input type="checkbox"/> Maxair <input type="checkbox"/> Xopenex® _____	2 puffs MDI every 4 hours as needed
<input type="checkbox"/> Xopenex® <input type="checkbox"/> 0.31, <input type="checkbox"/> 0.63, <input type="checkbox"/> 1.25 mg _____	1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Increase the dose of, or add:	
<input type="checkbox"/> Other _____	

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

EMERGENCY



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

<input type="checkbox"/> Accuneb® <input type="checkbox"/> 0.63, <input type="checkbox"/> 1.25 mg _____	1 unit nebulized every 20 minutes
<input type="checkbox"/> Albuterol <input type="checkbox"/> 1.25, <input type="checkbox"/> 2.5 mg _____	1 unit nebulized every 20 minutes
<input type="checkbox"/> Albuterol <input type="checkbox"/> Pro-Air <input type="checkbox"/> Proventil® _____	2 puffs MDI every 20 minutes
<input type="checkbox"/> Ventolin® <input type="checkbox"/> Maxair <input type="checkbox"/> Xopenex® _____	2 puffs MDI every 20 minutes
<input type="checkbox"/> Xopenex® <input type="checkbox"/> 0.31, <input type="checkbox"/> 0.63, <input type="checkbox"/> 1.25 mg _____	1 unit nebulized every 20 minutes
<input type="checkbox"/> Other _____	



Your asthma is getting worse fast:

- Fast-acting medicine did not help within 15-20 minutes
- Breathing is hard and fast
- Nose opens wide
- Ribs show
- Trouble walking and talking
- Lips blue • Fingernails blue

And/or Peak flow below _____

FOR MINORS ONLY:

- 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 patient and for physician file. For children under 18, send original to school nurse or child care provider.

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Asthma Treatment Plan Patient/Parent Instructions



The PACNJ Asthma Treatment Plan is designed to help everyone understand the steps necessary for the individual patient to achieve the goal of controlled asthma.

1. Patients/Parents/Guardians: Before taking this form to your Health Care Provider:

Complete the top left section with:

- Patient's name
- Patient's date of birth
- Patient's doctor's name & phone number
- Parent/Guardian's name & phone number
- An Emergency Contact person'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 you or your child to follow.

3. Patients/Parents/Guardians & Health Care Providers together:

Discuss and then complete the following areas:

- Patient's peak flow range in the Healthy, Caution and Emergency sections on the left side of the form
- Patient's asthma triggers on the right side of the form
- For Minors Only 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

This Asthma Treatment Plan is meant to assist, not replace, the clinical decision-making required to meet individual patient needs. Not all asthma medications are listed and the generic names are not listed.

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Maple Shade School District Self-Medication Form

New Jersey law permits students with life-threatening illness to carry medication with them and self-medicate as necessary. Students attending Maple Shade public schools who wish to take advantage of this law may do so under the following conditions:

1. The doctor has checked the box on the other side of the paper signifying that the student is capable and has been instructed in the proper method of self-administration and signed the form.
2. Parent/guardian must understand that the school employees or agents are not liable should the student be injured from self-administering medication and they "indemnify and hold harmless the school and its employees against any claims arising out of the self-administration of medicine by the pupil."
3. Parent/guardian must take responsibility for monitoring the expiration date on the medication so that students carry only up-to-date doses on their person.
4. Parent/guardian/student understand that students are responsible for the medication. It is to be used solely as prescribed by the physician and solely by the students it is prescribed for. No student shall share medication with another student, even if they believe they have the same prescribed medication.
5. Students who use the medication in the school building or on class/field trips are obliged to inform the school nurse or the activity supervisor of the circumstances requiring self-medication and the fact that they used the medication. Activity supervisors will relay this information to the school nurse for documentation. The only exception to this is athletes using medications. They will inform the trainer and/or coach.

Please read and sign this statement as well as the front of this form.

I indemnify and hold harmless the school and its employees against any injury or claims arising out of the self-administration by my child of this medication. We (parent/guardian & student) have read and fully understand all school policy/procedures for medication. I understand that this written request is only valid for the current school year.

Student Signature

Date

Parent/Guardian Signature

Date