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

Sponsored by AMERICAN LUNG ASSOCIATION. in NEW JERSEY

NJ Health New Jersey Department of Health

(Please Print)

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

HEALTHY (Green Zone)

Take daily control medicine(s). Some 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

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Advair® HFA ☐ 45, ☐ 115, ☐ 230	2 puffs twice a day
☐ Aerospan™	☐ 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, ☐ 500	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	

And/or Peak flow above ________

Remember to rinse your mouth after taking inhaled medicine.

If exercise triggers your asthma, take________________ ____ puff(s) ____minutes before exercise.

CAUTION (Yellow Zone)

Continue daily control medicine(s) and ADD quick-relief medicine(s).

You have *any* of these:
- Cough
- Mild wheeze
- Tight chest
- Coughing at night
- Other:__________

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.**

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)

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

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 ________

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
  - o Dust Mites, dust, stuffed animals, carpet
  - o Pollen - trees, grass, weeds
  - o Mold
  - o Pets - animal dander
  - o Pests - rodents, cockroaches
- ☐ Odors (Irritants)
  - o Cigarette smoke & second hand smoke
  - o Perfumes, cleaning products, scented products
  - o Smoke from burning wood, inside or outside
- ☐ Weather
  - o Sudden temperature change
  - o Extreme weather - hot and cold
  - o Ozone alert days
- ☐ Foods:
  - o ________
  - o ________
  - o ________
- ☐ Other:
  - o ________
  - o ________
  - o ________

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

[illegible]

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____________________ DATE________
Physician's Orders

PARENT/ SIGNATURE____________________

PHYSICIAN STAMP

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

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 *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 & 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 *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 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 Signature _____ Phone _____ Date _____

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WASHINGTON TOWNSHIP PUBLIC SCHOOLS **Attachment C.1-B (Cont.)**

Authorization Form for Student Self-Administration of Medications for Asthma and Other Potentially Life-threatening Illnesses and/or Life-Threatening Allergic Reactions

SECTION B: Physician's Certification (To be completed by *student's* physician)

Student's Name:_____ Age:_____ Grade:_____ School_____

Name of Medication:_____

Dosage:_____Frequency:_____ Oral:_____ Parenteral:_____

Possible Side Effects:_____

_____

Date When Medication Will Be Discontinued:_____

Specific Nature of Student's Illness/Condition:_____

_____

It is my understanding that the School Nurses of Washington Township Public Schools charged with the administration of medication may rely upon my directions as contained in this document. Students with asthma or other potentially life-threatening illnesses deemed sufficiently responsible by their physician and parent shall be permitted to have in their possession prescribed medication for the treatment and prevention of life-threatening illnesses or condition during school hours, athletic events and practices and field trips. I hereby deem the above named student to be sufficiently capable having been instructed in the proper method of self-administration of medication pursuant to Chapter 308 of the laws of 1993, to carry his/her prescribed medication of the medication listed above. I further certify that I am the physician who prescribed the medication and that the student named above is under my supervision as a patient for diagnosis and treatment. Any alteration to the above will occur only with written directions from the attending physician.

I certify that the above statements are true and that the student is physically fit to attend school and is free from contagious disease. He (she) would not be able to attend school if the medication is not administered during school hours.

_____ _____

Physician's Name (Please Print/Type) Physician's Signature

Address: _____

Date: _____ Telephone: _____

Affix physician's official stamp here:

Washington Township Public Schools **Attachment C.1-C**

Authorization Form for Student Self-Administration of Medications for Asthma and Other Potentially Life-threatening Illnesses and/or Life-Threatening Allergic Reactions

SECTION C: SCHOOL OFFICIAL'S REVIEW AND CONCURRENCE
(This section is to be completed by the *School Nurse and the School Physician.*)

SCHOOL NURSE AND SCHOOL PHYSICIAN

I have reviewed the parent's written authorization and the student's physician's written certification and agree that the above-referenced student is capable of self-administration of the medication prescribed by the student's physician.

School Nurse's Name (Print)	School Physician's Name (Print)
School Nurse's Signature	School Physician's Signature
Date	Date

Affix school physician's official stamp here:

Washington Township Public Schools **Attachment D**

ASTHMA QUESTIONNAIRE

If your child has Asthma, please complete the questionnaire below and return to the Health Office. Thank You!

Effectively managing asthma requires a partnership among the student, parent, the physician, and other adults who work with your child. To protect students and to guide staff, we ask that you fill in the information below. Guidelines are in place to contact you in the event of an emergency. Please follow the established procedure for administration of medication while at school. Please call the School Nurse if you have any concerns or questions.

Name: _____ Grade: _____ Teacher: _____

Identify the things which start an asthma episode (check all that apply to your child)

☐ Exercise
☐ Respiratory Infections
☐ Change in Temperature
☐ Animals (Specify below)
_____
☐ Food (Specify below)
_____
☐ Strong Odors or Fumes

☐ Chalk Dust
☐ Carpets in the Room
☐ Pollens
☐ Dust Mites
☐ Mold
☐ Other
_____

☐ Spring
☐ Fall/Autumn
☐ Year Round

1. What are the signs of an asthma attack in your child? _____
_____
2. If your child uses a Peak Flow Meter, please indicate his/her personal best Peak Flow number. _____
3. List all medication(s) your child takes.
_____
_____
4. Will your child need to take medication for asthma during the school day?
_____ Yes _____ No
If you answered "yes", please be sure to see the nurse to obtain the "*Request for Medication to be Administered at School*" form that must be filled out by your doctor and you.
5. Control of School Environment
List any environmental control measures, pre-medications, and/or dietary restrictions that the student needs to prevent an asthma episode:
_____
_____
6. Has your child ever been hospitalized for asthma? If yes, when? _____
7. Has your child ever been evaluated by an asthma/allergy specialist? If yes, when? _____

Parent Name (Please Print): _____

Parent Signature: _____ Date: _____