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

REVISED AUGUST 2014
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The Pediatric/Adult Asthma Coalition of New Jersey







(Please Print)		100.500	suresc	
Name		Date of Birth	Effective Date	715
Doctor	Parent (if ap	pplicable)	Emergency Contact	
Phone	Phone		Phone	
HEALTHY (Green Zone)	Take daily control n more effective with	a "spacer" - use	if directed.	Triggers Check all items that trigger
You have all of these: Breathing is good No cough or wheeze Sleep through the night Can work, exercise, and play	MEDICINE Advair® HFA 45, 115, Aerospan™ Alvesco® 80, 160 Dulera® 100, 200 Flovent® 44, 110, 220 Qvar® 40, 80 160 Symbicort® 80, 160 Advair Diskus® 100, 250, Asmanex® Twisthaler® 110, Flovent® Diskus® 50 100 Pulmicort Flexhaler® 90, Pulmicort Respules® (Budesonide) Singulair® (Montelukast) 4, Other	230	2 puffs twice a day wice a day wice a day wice a day P puffs twice a day	patient's asthma: Colds/flu Exercise Allergens Dust Mites, dust, stuffed animals, carpet Pollen - trees, grass, weeds Mold Pets - animal dander Pests - rodents cockroaches Codors (Irritants)
And/or Peak flow above	□ None		(48)	O Cigarette smok & second hand
If exercise triggers you		er to rinse your mouth a nuff(s)	after taking inhaled medicineminutes before exercise.	smoke
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). EDICINE HOW MUCH to take and HOW OFTEN to take it Albuterol MDI (Pro-alr® or Proventil® or Ventolin®) _2 puffs every 4 hours as needed Xopenex®			products, scented products Smoke from burning wood, inside or outsid Weather Sudden temperature change Extreme weath hot and cold Ozone alert day
Your asthma is getting worse fast: • Quick-relief medicine did not help within 15-20 minut • Breathing is hard or fast • Nose opens wide • Ribs sho • Trouble walking and talking • Lips blue • Fingernails blue • Other:	Asthma can be a li MEDICINE Albuterol MDI (Pro-air® or Xopenex® Albuterol 1.25, 2.5 m Duoneb®	HOW MUCH to Proventil® or Ventolin®) 19 131, □ 0.63, □ 1.25 mg	take and HOW OFTEN to take it 4 puffs every 20 minutes 4 puffs every 20 minutes 1 unit nebulized every 20 minutes 1 unit nebulized every 20 minutes	This asthma treatmer plan is meant to assis not replace, the clinic decision-making required to meet individual patient nee
ADAP may be generally as event in the section public sections of your distinct of the section of	sion to Self-administer Medication student is capable and has been instructed e proper method of self-administering of the nebulized inhaled medications named above cordance with NJ Law. student is not approved to self-medicate	PARENT! SIGNA	Physician's Orders	DATE

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.



Before taking this form to your Health Care Provider, complete the top left section with:

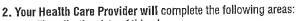
· Child's name

. 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



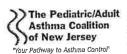
- · The effective date of this plan
- The medicine information for the Healthy, Caution and Emergency sections
- Your Health Care Provider will check the box next to the medication and check how much and how often to take it
- · Your Health Care Provider may check "OTHER" and:
 - Write in asthma medications 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
- 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

in its original	HORIZATION permission for my child to receive medication at school prescription container properly labeled by a pharma between the school nurse and my child's health care hat this information will be shared with school staff on a	cist or physician. I also gi e provider concerning my	ve permission for the release and exchange of			
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						
	request that my child self-administer his/her asthma	medication.	725			
Parent	Signature	Phone	Date			



PACKU approved Plan avail www.pacnj.org

The Prediction Address Condition of New Acres, a personnel by the American Load Association is New Acres; This pecification was supported by a great from the New Acres; Department of Pathshard Social Section 2014. The extension was reported by the U.S. Control for Bellevia Control and Acres (Association and Association and Association and Acres (Association and Association and Associat



WASHINGTON TOWNSHIP PUBLIC SCHOOLS

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: _____ School _____ Age: ____ Grade: ____ School _____ Name of Medication: Dosage:______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 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

<u>SECTION C</u>: 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:	
	0

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	ch start an asthma episode (check all that apply t	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	
a strong odors or runles			
1. What are the signs of an ast	thma attack in your'child?		
2. If your child uses a Peak Flo	w Meter, please indicate his/her personal best F	Peak Flow number.	
3. List all medication(s) your c		· · · · · · · · · · · · · · · · · · ·	
4. Will your child need to take	medication for asthma during the school day?		
If you answered "yes", plea that must be filled out by yo	se be sure to see the nurse to obtain the "Reque	est for Medication to be Administered at School" fo	rm
 Control of School Environm List any environmental conf asthma episode: 		estrictions that the student needs to prevent an	
	ospitalized for asthma? If yes, when?		
Has your child ever been ev	valuated by an asthma/allergy specialist? If yes, v	wnen?	
Parent Name (Please Print):			
Parent Signature:		Date:	