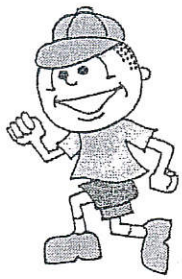
The Pediatric/Adult Asthma Coalition of New Jersey

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

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 circle 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.

The Pediatric/Adult Asthma Coalition of New Jersey, sponsored by the American Lung Association of New Jersey, and this publication are supported by a grant from the New Jersey Department of Health and Senior Services (NJDHSS), with funds provided by the U.S. Centers for Disease Control and Prevention (USCDCP) under Cooperative Agreement 5U59EH000206-2. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the NJDHSS or the USCDCP. Although this document has been funded wholly or in part by the United States Environmental Protection Agency under Agreements XA97256707-1, XA98284401-3 and XA97250908-0 to the American Lung Association of New Jersey, it has not gone through the Agency's publications review process and therefore, may not necessarily reflect the views of the Agency and no official endorsement should be inferred. Information in this publication is not intended to diagnose health problems or take the place of medical advice. For asthma or any medical condition, seek medical advice from your child's or your health care professional.

AMERICAN LUNG ASSOCIATION® *of New Jersey*

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"
Original PACNJ approved Plan available at www.pacnj.org

Sponsored by AMERICAN LUNG ASSOCIATION® of New Jersey

NEW JERSEY DEPARTMENT OF HEALTH SENIOR SERVICES

(Please Print)

Name	Date of Birth	Effective Date

Doctor	Parent/Guardian (if applicable)	Emergency Contact
Phone	Phone	Phone

HEALTHY

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 _____

Take daily medicine(s). All metered dose inhalers (MDI) to be used with spacers.

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Advair® 100, 250, 500	.1 inhalation twice a day
☐ Advair® HFA 45, 115, 230	.2 puffs MDI twice a day
☐ Asmanex® Twisthaler® 110, 220	.1 - 2 inhalations a day
☐ Flovent® 44, 110, 220	.2 inhalations twice a day
☐ Flovent® Diskus® 50 mcg	.1 inhalation twice a day
☐ Pulmicort Flexhaler® 90, 180	.1 - 2 inhalations once or twice a day
☐ Pulmicort Respules® 0.25, 0.5, 1.0	.1 unit nebulized once or twice a day
☐ Qvar® 40, 80	.2 inhalations twice a day
☐ Singulair 4, 5, 10 mg	.1 tablet daily
☐ Symbicort® 80, 160	.2 puffs MDI twice a day
☐ Other	

Remember to rinse your mouth after taking inhaled medicine.

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

CAUTION

You have *any* of these:
- Exposure to known trigger
- Cough
- Mild wheeze
- Tight chest
- Coughing at night
- Other:_____

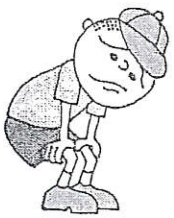
And/or Peak flow from _____ to _____

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

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Accuneb® 0.63, 1.25 mg	.1 unit nebulized every 4 hours as needed
☐ Albuterol 1.25, 2.5 mg	.1 unit nebulized every 4 hours as needed
☐ Albuterol ☐ Pro-Air ☐ Proventil®	.2 puffs MDI every 4 hours as needed
☐ Ventolin® ☐ Maxair ☐ Xopenex®	.2 puffs MDI every 4 hours as needed
☐ Xopenex® 0.31, 0.63, 1.25 mg	.1 unit nebulized every 4 hours as needed
☐ Increase the dose of, or add:	

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

EMERGENCY



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 _____

Take these medicines NOW and call 911.

Asthma can be a life-threatening illness. Do not wait!

☐ Accuneb® 0.63, 1.25 mg	.1 unit nebulized every 20 minutes
☐ Albuterol 1.25, 2.5 mg	.1 unit nebulized every 20 minutes
☐ Albuterol ☐ Pro-Air ☐ Proventil®	.2 puffs MDI every 20 minutes
☐ Ventolin® ☐ Maxair ☐ Xopenex®	2 puffs MDI every 20 minutes
☐ Xopenex® 0.31, 0.63, 1.25 mg	.1 unit nebulized every 20 minutes
☐ Other	

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.

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EFFECTIVE MARCH 2008

FOR MINORS ONLY:

☐ This student is capable and has been instructed in the proper method of self-administering of the 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.

FORM 4

STERLING HIGH SCHOOL DISTRICT
501 S. Warwick Road
Somerdale, NJ 08083-2175

PHYSICIAN'S CERTIFICATION for SELF-ADMINISTRATION of MEDICATION by PUPIL for PUPILS with ASTHMA or OTHER POTENTIALLY LIFE-THREATENING ILLNESSES

STUDENT'S NAME: _____ AGE: _____ GRADE: _____

MEDICATION: _____ Rt. of Administration: _____

DOSAGE: _____ FREQUENCY: _____

POSSIBLE SIDE EFFECTS: _____

NAME OF ILLNESS/CONDITION: _____

The minor individual named above is my patient. I understand that this patient is a pupil in your school district.

I further understand that Chapter 308 of the Laws of 1993 allows the parents or guardians of a pupil who has asthma or other potentially life-threatening illness to authorize self-administration of medication by the pupil so long as the pupil's physician certifies to the school district that the pupil is capable of, and has been instructed in, the proper method of self-administration of medication.

My patient suffers from the illness or condition identified above and is required to take the medication also identified above.

My patient is capable of, and has been instructed in, the proper method of self-administration of this medication. In the event that the medication which I have prescribed is changed in the future, I will either assure that my patient remains capable of, and has been instructed in the proper method of self-administration of said medication, or will notify the school district that my patient is no longer capable of, or has not been instructed in, the proper method of such self-administration.

I understand that the authorization by my patient's parents or guardians is effective only for the current school year and must be reauthorized by them for each future school year. Any such reauthorization by my patient's parents or guardians for any future school year must be accompanied by a new certification by me.

_____ _____
Date PHYSICIAN'S SIGNATURE

_____ _____
Phone # Print Physician's Name

_____ _____ _____ _____
Street Town State Zip

STERLING HIGH SCHOOL DISTRICT
501 S. Warwick Road
Somerdale, NJ 08083-2175

PARENT'S AUTHORIZATION for SELF-ADMINISTRATION of MEDICATION by PUPIL

STUDENT'S NAME: _____ AGE: _____ GRADE: _____

Nature of Illness/Condition: _____

Type of Medication: _____

We, the undersigned, are the parents/guardians of the pupil named above.

We have been advised by you that legislation has been enacted allowing parents or guardians of a pupil who has asthma or another potentially life-threatening illness to authorize self-administration of medication by the pupil so long as the pupil's physician certifies to you that the pupil is capable of, and has been instructed in, the proper method of self-administration of medication. We have also been advised by you that if we do give this authorization, the school district and its employees and agents will incur no liability as a result of any injury arising from self-administration of medication by the pupil.

The pupil named above suffers from the illness or condition identified and is required to take the stated medication .

We authorize the pupil named above to administer this medication to him/herself while the pupil is under your jurisdiction.

We acknowledge that the school district and its employees and agents shall incur no liability as a result of any injury arising from the self-administration of medication by the pupil and we agree to indemnify and hold harmless the school district and its employees and agents against any claims arising out of the self-administration of medication by the pupil.

We understand that this authorization only applies to this current school year. We have the right to choose whether or not to furnish a new authorization for each future school year.

NOTE: Medications brought to school must be prescription labeled.

_____
PARENT/GUARDIAN * DATE

_____
PARENT/GUARDIAN* DATE

*In any case involving two parents or more than one guardian, all of the parents and guardians must sign the written authorization.