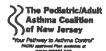
Asthma Treatment Plan — Student (This asthma action plan meets NJ Law N.J.S.A. 18A:40-12.8) (Physician's Orders)







(Please Print)

Name			Date of Birth	Effective Date	<u> </u>		
Doctor		Parent/Guardian (if applicable)	Emergency Contact			
Phone	, "	Phone		Phone	 .		
HEALTHY	(Green Zone)	Take daily contro more effective w	il medicine(s). Some ith a "spacer" – use	inhalers may be if directed.	Triggers Check all items		
	You have <u>all</u> of these: Breathing is good No cough or wheeze Sleep through the night Can work, exercise, and play	☐ Aerospan M ☐ Alvesco® ☐ 80, ☐ 160 ☐ ☐ Dulera® ☐ 100, ☐ 200 ☐ ☐ Hovent® ☐ 144, ☐ 110, ☐ ☐ Ovar® ☐ 40, ☐ 80 ☐ 160 ☐ ☐ Advair Diskus® ☐ 100, ☐	, \[\] 230 \[\] 2 puffs t \[\] 1, \[\] 2 puffs t \[220 \] 2 puffs t \[\] 1, \[\] 1, \[\] 250, \[\] 500 \[1 inhalat	2 puffs twice a day 2 puffs twice a day wice a day wice a day 2 puffs twice a day 2 puffs twice a day lion twice a day	that trigger patient's asthma: Colds/tlu Exercise Allergens Dust Mites, dust, stuffed animals, carpet Pollen - trees, grass, weeds Mold		
And/or Peak	flow above	□ Pulmicort Flexhaler® □ 90 □ Pulmicort Resputes® (Budesonk □ Singulair® (Montelukast) □ 4 □ Other □ None Reme	,	2 inhalations once or twice a day tion twice a day 2 inhalations once or twice a day 2 inhalations once or twice a day bulized once or twice a day daily	dander Pests - rodents, cockroaches Glodors (Irritants) Cigarette smoke & second hand		
If exercise triggers your asthma, take puff(s)minutes before exercise. OR A PERSONNEL CHEATING							
GAUTION	(Yallow Zone) You have <u>any</u> of these:		ol medicine(s) and ADD		products, scented products		
15-20 minutes of 2 times and syndoctor or go to	Cough Mild wheeze Tight chest Coughing at night Other: edicine does not help within or has been used more than night emergency room. ow from to	□ Xopenex® □ Albuterol □ 1.25, □ 2.5 m □ Duoneb® □ □ Xopenex® (Levalbuterol) □ 0 □ Combivent Respimat® □ □ Increase the dose of, or add □ □ Other ■ If quick-relief me	Proventil® or Ventolin®) _2 puff2 puff1 unit1 unit1 unit1 inha	is every 4 hours as needed nebulized every 4 hours as needed nebulized every 4 hours as needed nebulized every 4 hours as needed lation 4 times a day	Smoke from burning wood, inside or outside U Weather Sudden temperature		
And/or Peak flow below	Your asthma is getting worse fast: • Quick-relief medicine did not help within 15-20 minute • Breathing is hard or fast • Nose opens wide • Ribs sho • Trouble walking and talking • Lips blue • Fingernails blue • Other:	Asthma can be a MEDICINE Albuterol MDI (Pro-air Vopenex Albuterol 1.25, 2.	HOW MUCH to Por Proventil® or Ventolin®) 5 mg 0.31, [] 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	This asthma treatment plan is meant to assist, not replace, the clinical decision-making required to meet individual patient needs.		
ab agreedy ages has be too any ages for him. Gold of Producting Supergra- te affect on him in many report to the 6.5 cannot be proposed years for formation for a program of processed from the lower colleges and second.	Appendix the relative threat-promapular direct things to be a 12 to intelligence between notices of the 12 to intelligence between notices and the 12 to intelligence between notices and the 12 to intelligence between	sion to Self-administer Medica student is capable and has been instru- proper method of self-administering nebulized inhaled medications named ordance with NJ Law. student is not approved to self-medi	of the above PARENT/GUARDIAN SIGNAT	Physician's Orders TURE	DATE		

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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/Guardians: Before taking this form to your Health Care Provider, complete the top left section with:
 - · Child's name
- . Child's doctor's name & phone number
- Parent/Guardian's name

- . Child's date of birth
- An Emergency Contact person's name & phone number
- & 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/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 in its original prescription container properly labeled by a pharmacis information between the school nurse and my child's health care punderstand that this information will be shared with school staff on a number of the property	st or physician. I also giv provider concerning my	e permission for the release and exchange of				
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.						
Descrit@uardian Cianahua	Dhan	D.1.				
Parent/Guardian Signature	Phone	Date				



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