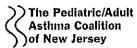
# Asthma Treatment Plan (This asthma action plan meets NJ Law N.J.S.A. 18A:40-12.8) (Physician's Orders)







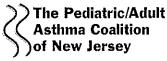


| (Please Print)   | LUN 11,0,001 V TOTAL TO TELO  | "Your Pat!"<br>PACH I   | hway to Asthma Control*<br>approved Plan ava∃able at<br>www.pacnj.org  | ASSOCIATION. Y SENIOR SERIOR S | E   |  |  |
|--|---|---|--|--|---|--|--|
| Name   |   |   | Date of Birth  | Effective Date   | ,   |  |  |
| Doctor   |   | Parent/Guardian (if app   | licable)   | Emergency Contact  |   |  |  |
| Phone  |   | Phone   |  | Phone  |   |  |  |
| HEALTHY You h  |   | Take daily medicine(s). Some metered dose inhalers may be more effective with a "spacer" – use if directed  MEDICINE HOW MUCH to take and HOW OFTEN to take it  Triggers  |  |  |   |  |  |
| • No co<br>• Sleep<br>the ni<br>• Can w<br>and p   | ork, exercise,<br>lay   | ☐ Advair® ☐ 100, ☐ 250, ☐ Advair® HFA ☐ 45, ☐ 115 ☐ Alvesco® ☐ 80, ☐ 160 ☐ Asmanex® Twisthaler® ☐ 1 ☐ Flovent® ☐ 44, ☐ 110, ☐ ☐ Flovent® Diskus® ☐ 50 ☐ ☐ Pulmicort Flexhaler® ☐ 90   | 500  | ion twice a day  ADI twice a day  2 puffs MDI twice a day  2 inhalations  once or  twice a day  ion twice a day  2 inhalations  once or  twice a day  bulized  once or  twice a day  puffs MDI twice a day  daily  | check atl Items that trigger patient's asthma  day twice a day twice a day twice a day day  Clgarette Smoke & second hand smoke Colds/Flu Dust mites, dust, stuffed animals, carnet |  |  |
| And/or Peak flow abov  | 'e  | None  | to rince your mouth of   | ter taking inhaled medicine.   | D Ozone alert days  |  |  |
| If exercise tr   | iggers your asthma  |   | •  | minutes before exercise.   | cockroaches   |  |  |
| CAUTION  |   | Continue daily medi   | cine(s) and add fa   | st-acting medicine(s).   | • □ Pets - animal<br>dander<br>□ Plants, flowers,   |  |  |
| You have <u>any</u> of these:  Exposure to known trigger  Cough  Mild wheeze  Tight chest  Coughing at night  Other:   |   | MEDICINE HOW MUCH to take and HOW OFTEN to take it  |  | cut grass, pollen  Strong odors, perfumes, clean- ing products, scented products  Sudden tempera- ture change  Wood Smoke Foods:   |   |  |  |
|  |   | ☐ Accuneb® ☐ 0.63, ☐ 1.25 mg1 unit nebulized every 4 hours as needed ☐ Albuterol ☐ 1.25, ☐ 2.5 mg1 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 mg1 unit nebulized every 4 hours as needed ☐ Increase the dose of, or add: ☐ Other |  |  |   |  |  |
| And/or Peak flow from_   | to  | If fast-acting medicine is needed more than 2 times a week, except before exercise, then call your doctor.  |  |  |   |  |  |
| Fast-aci help with Nose of Ribs sh   | thma is worse fast: ing medicine did not hin 15-20 minutes ng is hard and fast bens wide ow walking and talking re • Fingernalls blue | Take these me  Asthma can be a li  Accuneb® — 0.63, — 1.25  Albuterol — 1.25, — 2.5 m  Albuterol — Pro-Air — Prov.  Ventolin® — Maxair — Xop  Xopenex® — 0.31, — 0.63,  Other   | ife-threatening ill<br>mg1 unit nebul<br>g1 unit nebul<br>yentil <sup>®</sup> 2 puffs MDI<br>enex <sup>®</sup> 2 puffs MOI | Iness. Do not wait!<br>lized every 20 minutes<br>lized every 20 minutes<br>every 20 minutes<br>every 20 minutes  | This asthma treatment plan is meant to assist, not replace, the clinical decisionmaking required to meet individual patient needs.  |  |  |
| Intention 4. All other broading of the large powers by the Action<br>processing free feature, and the sub-year responsed by the<br>control of the large power of the large free feature (1968), and<br>the large free feature of the large free feature (1968), and<br>has provided by the Schreck of December of the Processing (1968), and<br>the Copyright of the Action 2008 of the Copyright of the<br>providing of the Action 2008 of the Copyright of the<br>ACTION SCHRECK OF THE ACTION ACTION ACTION AND<br>ACTION ACTION | proper method of sel  | le and has been instructed in the<br>f-administering of the non-nebulized<br>named above in accordance with   | PHYSICIAN/APN/PA SIGNATU<br>PARENT/GUARDIAN SIGNATU<br>PHYSICIAN STAMP   | ire  | DATE  |  |  |

REVISED MAY 2009 Permission to reproduce blank form www.paorl.org

 $\ \square$  This student is <u>not</u> approved to self-medicate.

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



"Your Pathway to Asthma Control" 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 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

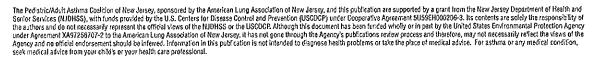
This Asthma Treatment Plan is meant to assist, not replace, the clinical decision-making required to meet individual patient needs. Not all asthma medications are listed and the generic names are not listed.

#### Discialmers:

The use of this Website/PACNJ Asthma Treatment Plan and its content is at your own risk. The content is provided on an "as is" basis. The American Lung Association of the Mid-Atlantic (ALAM-A), the Pediatric/Adult Asthma Coalition of New Jersey and all affiliates disclaim all warranties, express or implied, statutory or otherwise, including but not limited to the implied warranties or merchantability, non-infringement of third parties' rights, and fitness for a particular purpose.

ALAM-A makes no representations or warranties about the accuracy, reliability, completeness, currency, or timeliness of the content. ALAM-A makes no warranty, representation or guaranty that the information will be uninterrupted or error free or that any defects can be corrected.

In no event shall ALAM-A be liable for any damages (including, without limitation, incidental and consequential damages, personal injury/wrongful death, lost profits, or damages resulting from data or business interruption) resulting from the use or inability to use the content of this Asthma Treatment Plan whether based on warranty, contract, tort or any other legal theory, and whether or not ALAM-A is advised of the possibility of such damages. ALAM-A and its affiliates are not liable for any claim, whatsoever, caused by your use or misuse of the Asthma Treatment Plan, nor of this website.





# 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.

| valid for the current school year. |      |                           |      |  |
|------------------------------------|------|---------------------------|------|--|
|                                    |      | Parent/Guardian Signature |      |  |
| Student Signature                  | Date |                           | Date |  |