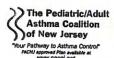
## Asthma Treatment Plan — Student (This asthma action plan meets NJ Law N.J.S.A. 18A:40-12.8) (Physician's Orders)









REVISED JULY 2012

Name			gijes mas	Date of Birth	Effective Date	
Doctor			Parent/Guardian (if applicable) Emergency Contact			
Phone			Phone		Phone	
HEALTHY	You have <u>all</u> of these:  • Breathing is good  • No cough or wheeze  • Sleep through the night  • Can work, exercise, and play	MEDIC Advai Alveso Dulero	e effective with a NE  10 HFA   45,   115,   20  10   80,   160  10   100,   200  10   44   110   220	302 puffs tw1,2 puffs tw2 puffs tw2 puffs tw2 puffs tw	d HOW OFTEN to take it	Trigger Check all items that trigger patient's asthm Colds/flu Exercise Allergens Dust Mites, dust, stuffed animals, carp Pollen - trees grass, weeds
	flow above	☐ Plover ☐ Pulmic ☐ Singur ☐ Other ☐ None	cort Flexhaler®   90,   18 ort Respules® (Budesonide)   0 air® (Montelukast)   4,   5,	1 innalatic 30	on twice a day inhalations  once or  twice a day ulized  once or  twice a day ally  ter taking inhaled medicin	o Mold O Pets - animal dander O Pests - roden cockroaches O Odors (Irritants) Cigarette smo & second han
	If exercise triggers your	asthma, ta	ke this medicine		minutes before exercis	e. O Perfumes,
f quick-relief me 5-20 minutes of 2 times and sym doctor or go to to And/or Peak	You have any of these Cough Mild wheeze Tight chest Coughing at night Other:  edicine does not help within or has been used more than nptoms persist, call your the emergency room.  flow from to	MEDICINE HOW MUCH to take and HOW OFTEN to take it  Combivent®   Maxair®   Xopenex®   2 puffs every 4 hours as needed  Ventolin®   Pro-Air®   Proventil®   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  Increase the dose of, or add:				products, scented products  Smoke from burning wood inside or outs  Weather Sudden temperature
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  Peak flow Delow Other:  Other:			penex® (Levalbuterol) □ 0.31, □ 0.63, □ 1.25 mg1 unit nebulized every 20 minutes			Other:
chainment. The set of an Week (ACC) will need or in a 14 beet. He kneem keep water for the least and this machine all me the three department or an extendition. The ACC was the machine to see that the set of t	I se tratte de la companya de la constante de la companya del la companya de la companya del la companya de la companya del la com	s student is cap ne proper meth nebulized inha ccordance with	-administer Medication: able and has been instructed of of self-administering of the led medications named above NJ Law.	PHYSICIAN/APN/PA SIGNATUR PARENT/GUARDIAN SIGNATUR PHYSICIAN STAMP		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

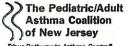
The PACNJ Asthma Treatment Plan is designed to help everyone understand the steps necessary for the individual student to achieve the goal of controlled asthma.

- 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 in its original prescription container properly labeled by a plinformation between the school nurse and my child's healt understand that this information will be shared with school state.	harmacist or physician. I also give peri th care provider concerning my child's	mission for the release and exchange of
Parent/Guardian Signature	Phone	Date
STUDENT AUTHORIZATION FOR SELF ADMINISTRATION O  RECOMMENDATIONS ARE EFFECTIVE FOR ONE (1) SCHOOL  ☐ I do request that my child be ALLOWED to carry the follow in school pursuant to N.J.A.C:.6A:16-2.3. I give permission f Plan for the current school year as I consider him/her to be medication. Medication must be kept in its original prescri shall incur no liability as a result of any condition or injury on this form. I indemnify and hold harmless the School Distr or lack of administration of this medication by the student.	on year only and must be renewating medication for my child to self-administer medication are responsible and capable of transporting intion container. I understand that the sarising from the self-administration by the rict, its agents and employees against any	for self-administration n, as prescribed in this Asthma Treatment ng, storing and self-administration of the chool district, agents and its employees the student of the medication prescribed
☐ I DO NOT request that my child self-administer his/her as	thma medication.	
Parent/Guardian Signature	Phone	Date



"Your Pathway to Asthma Control PACNJ approved Plan available at www.pacnj.org Installment: The use of this Whichigh(CAU) Joshum Entered Pian and its costant is a year countries. The content is provided on an "as in" basis. The American Lung Association of the Mid-Allantic (MLAM-A), the Prinder-(Adult Asthum Coullision of water pages and different in claims and in association, express or impost, established or coloration, backlond for the finished to be signed warranties or metaschability, con-estingment of their general field pages or contributions or warranties stored an expression of the signed warranties or the contribution of the co

AMERICAN LUNG ASSOCIATION.

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