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
   - Child’s date of birth
   - An Emergency Contact person’s name & phone number
   - Parent/Guardian’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 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 prescribed in the Asthma Treatment Plan. Medication must be provided in its original prescription container properly labeled by a pharmacist or physician. I also give permission for the release and exchange of information between the school nurse and my child’s health care provider concerning my child’s health and medications. In addition, I understand that this information will be shared with school staff on a need to know basis.

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.

Parent/Guardian Signature

Phone

Date

The Pediatric/Adult Asthma Coalition of New Jersey

Your Pathway to Asthma Control

www.pacnj.org

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AMERICAN LUNG ASSOCIATION

in New Jersey
Asthma Treatment Plan – Student

(Please Print)

Name ____________________________ Date of Birth ____________ Effective Date ____________

Doctor ____________________________ Parent/Guardian (if applicable) ____________ Emergency Contact ____________

Phone ____________________________ Phone ____________________________

HEALTHY (Green Zone) ⚫⚫⚫

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 control medicine(s). Some inhalers may be more effective with a “spacer” – use if directed.

<table>
<thead>
<tr>
<th>MEDICINE</th>
<th>HOW MUCH to take and HOW OFTEN to take it</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advair® HFA</td>
<td>2 puffs twice a day</td>
</tr>
<tr>
<td>Alvesco® 80, 160</td>
<td>1, 2 puffs twice a day</td>
</tr>
<tr>
<td>Albuterol 100, 200</td>
<td>2 puffs twice a day</td>
</tr>
<tr>
<td>Flovent® 44, 110, 220</td>
<td>2 puffs twice a day</td>
</tr>
<tr>
<td>Qvar® 40, 80</td>
<td>1, 2 puffs twice a day</td>
</tr>
<tr>
<td>Symbicort® 80, 160</td>
<td>1, 2 puffs twice a day</td>
</tr>
<tr>
<td>Advair™ Diskus® 100, 250, 500</td>
<td>1 inhalation twice a day</td>
</tr>
<tr>
<td>Asmanex™ Twisthaler® 110, 220</td>
<td>1, 2 inhalations once or twice a day</td>
</tr>
<tr>
<td>Flovent™ Diskus® 50 100, 250</td>
<td>1 inhalation twice a day</td>
</tr>
<tr>
<td>Pulmicort™ Flexhaler® 90, 180</td>
<td>1, 2 inhalations once or twice a day</td>
</tr>
<tr>
<td>Pulmicort Resuples® (Beutopar) 0.25, 0.5, 10</td>
<td>1 unit nebulized once or twice a day</td>
</tr>
<tr>
<td>Symbicort® (Montelukast) 4, 5, 10 mg</td>
<td>1 tablet daily</td>
</tr>
</tbody>
</table>

Remember to rinse your mouth after taking Inhaledmedicines.

If exercise triggers your asthma, take this medicine __________________ minutes before exercise.

CAUTION (Yellow Zone) ⚫⚫

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).

<table>
<thead>
<tr>
<th>MEDICINE</th>
<th>HOW MUCH to take and HOW OFTEN to take it</th>
</tr>
</thead>
<tbody>
<tr>
<td>Combivent® Maxair® Xopenex®</td>
<td>2 puffs every 4 hours as needed</td>
</tr>
<tr>
<td>Ventolin® Pro-Air® Proventil®</td>
<td>2 puffs every 4 hours as needed</td>
</tr>
<tr>
<td>Albuterol 1.25, 2.5 mg</td>
<td>1 unit nebulized every 4 hours as needed</td>
</tr>
<tr>
<td>Duoneb®</td>
<td>1 unit nebulized every 4 hours as needed</td>
</tr>
<tr>
<td>Xopenex® (Levobuterol)</td>
<td>0.31, 0.63, 1.25 mg</td>
</tr>
<tr>
<td>Increase the dose of, or add: Other: __________________</td>
<td></td>
</tr>
</tbody>
</table>

• If quick-relief medicine is needed more than 2 times a week, except before exercise, then call your doctor.

EMERGENCY (Red Zone) ⚫⚫⚫

Your asthma is 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
• Other: __________________

And/or Peak flow below ____________

Take these medicines NOW and CALL 911.
Asthma can be a life-threatening illness. Do not wait!

<table>
<thead>
<tr>
<th>MEDICINE</th>
<th>HOW MUCH to take and HOW OFTEN to take it</th>
</tr>
</thead>
<tbody>
<tr>
<td>Combivent® Maxair® Xopenex®</td>
<td>2 puffs every 20 minutes</td>
</tr>
<tr>
<td>Ventolin® Pro-Air® Proventil®</td>
<td>2 puffs every 20 minutes</td>
</tr>
<tr>
<td>Albuterol 1.25, 2.5 mg</td>
<td>1 unit nebulized every 20 minutes</td>
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<td>Xopenex® (Levobuterol)</td>
<td>0.31, 0.63, 1.25 mg</td>
</tr>
<tr>
<td>Other: __________________</td>
<td></td>
</tr>
</tbody>
</table>

Permission to Self-administer Medication:
☐ This student is capable and has been instructed in the proper method of self-administration of the non-nebulized 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 parent and for physician file, send original to school nurse or child care provider.