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"
PACNJ approved Plan available at www.pacnj.org

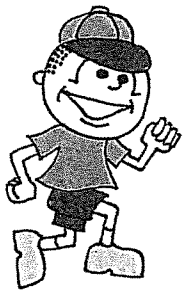
Sponsored by AMERICAN LUNG ASSOCIATION® IN NEW JERSEY

NEW JERSEY DEPARTMENT HEALTH SENIOR SERVICES

(Please Print)

Name	Date of Birth	Effective Date
Doctor Phone	Parent/Guardian (if applicable) Phone	Emergency Contact 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). 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
☐ Advair® ☐ 100, ☐ 250, ☐ 500	1 inhalation twice a day
☐ Advair® HFA ☐ 45, ☐ 115, ☐ 230	2 puffs MDI twice a day
☐ Alvesco® ☐ 80, ☐ 160	☐ 1, ☐ 2 puffs MDI twice a day
☐ Asmanex® Twisthaler® ☐ 110, ☐ 220	☐ 1, ☐ 2 inhalations ☐ once or ☐ twice a day
☐ Flovent® ☐ 44, ☐ 110, ☐ 220	2 puffs MDI twice a day
☐ Flovent® Diskus® ☐ 50 ☐ 100 ☐ 250	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	☐ 1, ☐ 2 puffs MDI twice a day
☐ Singulair ☐ 4, ☐ 5, ☐ 10 mg	1 tablet daily
☐ Symbicort® ☐ 80, ☐ 160	☐ 1, ☐ 2 puffs MDI twice a day
☐ Other	
☐ None	

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:_____

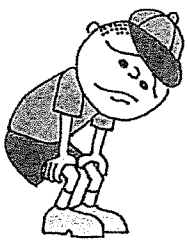
And/or Peak flow from_____ to_____

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:	
☐ Other	

➡ **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
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☐ 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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REVISED MAY 2009

FOR MINORS ONLY:

☐ This student is capable and has been instructed in the proper method of self-administering 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 patient and for physician file. For children under 18, send original to school nurse or child care provider.

MEDICATION ADMINISTRATION FORM

I request that the enclosed medication in the original container be administered to my child as prescribed, and shall release school personnel from all liability. **This includes ALL over the counter medication** e.g.Tylenol, Ibuprophen, Benadryl, cough syrup, etc.

Name of Child _____ Grade _____

Name of Medication _____

Dosage _____

Purpose _____

_____

_____ _____

Parent/Guardian Signature Date

****

TO BE FILLED IN BY SCHOOL NURSE

Prescription # _____ Date_____

Pharmacy _____ Phone _____

Name of Medication_____

Name of Physician _____ Phone _____

Of Tablets Received _____

****

PHYSICIAN'S ORDERS

Name of Patient_____

Name of Medication_____

Date of Prescription_____

Dosage_____

Purpose_____

COMMENTS_____

_____

Doctor's Name (please print) Doctor's Signature Date

SCHOOL ASTHMA RECORD

Child's Name_____ Date_____

Parent's Name_____ Phone(home)_____

Address_____ Phone(work)_____

Physician Treating Child's Asthma_____ Phone#_____

1. Briefly describe what causes your child's asthma symptoms:_____

_____

2. Does he or she do breathing exercises that are helpful in managing asthma? _____

3. In which sports can the child fully participate?_____

4. Does exercise induce episodes of asthma? If so, list types of exercise._____

_____

5. Do certain weather conditions affect your child's asthma? If so, list them._____

_____

6. Name the medication taken routinely, the dose, how often taken, when, and under what circumstances additional doses should be given_____

_____

7. Does your child experience any side effects to these medications? If so list_____

_____

8. Does your child understand asthma and what he or she should do to manage it?_____

9. How do you want the school to treat an episode of asthma if it should occur?_____

_____

10. Approximately how often does the child have an acute episode?_____

11. If the child does not respond to medication, what action do you advise school personnel to take? _____

_____

12. Does your child need an inhaler for school? No_____ Yes _____ *If yes, please send in the inhaler with the asthma treatment plan signed by parent and physician.*

Comments: _____

_____

Parent/Guardian Signature

_____

Please Print

Name: _____ Grade: _____

Allergy: _____

Medication: _____

Emergency Contacts:

1. _____ Phone: _____ Relationship: _____

2. _____ Phone: _____ Relationship: _____

3. _____ Phone: _____ Relationship: _____

Doctor: _____ Phone: _____

Parent/Guardian Signature: _____

Epipen