Asthma Treatment Plan – Student

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









friese rint						
Name		Date of Birth		Effective Date		
octor		Parent/Guardian (if applicable)		Emergency Contact		
Phone		Phone		Phone		
You have all of these: Breathing is good No cough or wheeze Sleep through the night Can work, exercise, and play	MEDIC Adva Aero Alves Dulei Flove Qvar Symi Adva Asma Flove Pulm Singi	ir® HFA	"spacer" – use i HOW MUCH to take ar 2 puffs to 1,	if directed. Ind HOW OFTEN to take it Wice a day 2 puffs twice a day 2 puffs twice a day Wice a day 2 puffs twice a day 2 puffs twice a day 3 puffs twice a day 4 puffs twice a day 5 inhalations once or twice a day 6 inhalations once or twice a day 7 inhalations once or twice a day 8 inhalations once or twice a day 8 inhalations once or twice a day 8 inhalations once or twice a day 8 inhalations once or twice a day	a Data animal	
And/or Peak flow above	☐ Othe ☐ None)	to vince your mouth o	fter taking inhaled medicine	Odors (Irritants) Cigarette smoke Second hand	
N.	GYAN A	na, take	puff(s) _	minutes before exercise.		
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 It times and symptoms persist, call your doctor or go to the emergency room. And/or Peak flow from to	MEDIC Albut Xope Albut Duor Xope Com Incre Othe	terol MDI (Pro-air® or Proven enex®terol	HOW MUCH to take ar til® or Ventolin®) _2 puffs	s 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	scented products Smoke from burning wood, inside or outside Weather Sudden temperature change Extreme weather hot and cold Ozone alert days Foods:	
Your asthma is getting worse fast: • Quick-relief medicine did not help within 15-20 mi • Breathing is hard or fast • Nose opens wide • Ribs: • Trouble walking and talk • Lips blue • Fingernails b: • Other:	As ME when the show ing ing lue in the show ing ing ing ing in the show ing in the show in the sh	Albuterol	HOW MUCH to oventil® or Ventolin®)	take and HOW OFTEN to take it 4 puffs every 20 minutes 4 puffs every 20 minutes 1 unit nebulized every 20 minutes 1 inhalation 4 times a day	□ Other: ○	
procided on an "to a" beam. The American Lung Association of the Medidantic (ALAMAI), the Professiolated, Authors Cheeline of their, Juney and all Eiline Actails and warmarks, segless or theybol, actailang or attention, proceedings but and inheline their implications are of their activities of their control of their state of their their propose. ALAMA makes are compression or warmarks about the accuracy, missible, complete and, currency, or simplesses of the		elf-administer Medication: capable and has been instructed	PHYSICIAN/APN/PA SIGNAT	'UREPhysician's Orders	DATE	

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in the proper method of self-administering of the non-nebulized inhaled medications named above in accordance with NJ Law.

☐ This student is <u>not</u> approved to self-medicate.

PHYSICIAN STAMP

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.

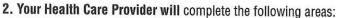
1. Parents/Guardians: Before taking this form to your Health Care Provider, complete the top left section with:

Child's nameChild's date of birth

· Child's doctor's name & phone number

Parent/Guardian's name

& phone number



. 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

An Emergency Contact person's name & phone number

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						
□ I DO NOT request that my child self-administer his/her asthma medication.						
Parent/Guardian Signature	Phone	Date				



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