

## **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 circle 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.**

#### **Disclaimers:**

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# Asthma Treatment Plan

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



"Your Pathway to Asthma Control"  
Original PACNJ approved Plan available at  
www.pacnj.org



**(Please Print)**

Name	Date of Birth	Effective Date
Doctor	Parent/Guardian (if applicable)	Emergency Contact
Phone	Phone	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). All metered dose inhalers (MDI) to be used with spacers.

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
<input type="checkbox"/> Advair® 100, 250, 500 . . . . .	1 inhalation twice a day
<input type="checkbox"/> Advair® HFA 45, 115, 230 . . . . .	2 puffs MDI twice a day
<input type="checkbox"/> Asmanex® Twisthaler® 110, 220 . . .	1 - 2 inhalations a day
<input type="checkbox"/> Flovent® 44, 110, 220 . . . . .	2 inhalations twice a day
<input type="checkbox"/> Flovent® Diskus® 50 mcg . . . . .	1 inhalation twice a day
<input type="checkbox"/> Pulmicort Flexhaler® 90, 180 . . . .	1 - 2 inhalations once or twice a day
<input type="checkbox"/> Pulmicort Respules® 0.25, 0.5, 1.0.	1 unit nebulized once or twice a day
<input type="checkbox"/> Qvar® 40, 80 . . . . .	2 inhalations twice a day
<input type="checkbox"/> Singulair 4, 5, 10 mg . . . . .	1 tablet daily
<input type="checkbox"/> Symbicort® 80, 160 . . . . .	2 puffs MDI twice a day
<input type="checkbox"/> Other	

*Remember to rinse your mouth after taking inhaled medicine.*

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

## 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.

## 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
<input type="checkbox"/> Accuneb® 0.63, 1.25 mg . . . . .	1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Albuterol 1.25, 2.5 mg . . . . .	1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Albuterol <input type="checkbox"/> Pro-Air <input type="checkbox"/> Proventil®	.2 puffs MDI every 4 hours as needed
<input type="checkbox"/> Ventolin® <input type="checkbox"/> Maxair <input type="checkbox"/> Xopenex®	.2 puffs MDI every 4 hours as needed
<input type="checkbox"/> Xopenex® 0.31, 0.63, 1.25 mg . .	1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Increase the dose of, or add:	

**➡ 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
- Ventolin®  Maxair  Xopenex® 2 puffs MDI every 20 minutes
- Xopenex® 0.31, 0.63, 1.25 mg . . 1 unit nebulized every 20 minutes
- Other

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**EFFECTIVE MARCH 2008**  
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Approved by the New Jersey Thoracic Society

### FOR MINORS ONLY:

- This student is capable and has been instructed in the proper method of self-administering of the 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.

**EASTERN CAMDEN COUNTY REGIONAL SCHOOL DISTRICT**  
**Department of Student Health Services**

PARENT PERMISSION FORM TO SELF MEDICATE  
ASTHMA

Senior High School  
Nurse  
784-4441 x 1136

Intermediate High School  
Nurse  
784-4441 x 1250

Date \_\_\_\_\_

To the Parent(s)/Guardian(s) of \_\_\_\_\_ ID# \_\_\_\_\_

Pursuant to Title 18A:40-12.3et seq., students who have a potentially life threatening illness\*, are permitted, when capable, to carry and self-administer prescribed medication. The Board of Education will grant permission for a student to self medicate under condition that the district and its employees or agents shall incur no liability as a result of any injury arising from self medication. Parent(s) or guardian(s) agree to supply the following:

1. Written authorization from parent(s) or guardian(s) for self-administration of medication by the student. This authorization shall be a signed, notarized statement that the district, it's employees and agents shall incur no liability as a result of injury arising from the self-administration of medication by the pupil. The above may be notarized in a District Guidance Office.

2. Written certification from the student's physician for self-administration of medication.

Per statute, this permission is granted for one school year.

Necessary forms are available from district health offices.

\*Per New Jersey State Department of Health and the New Jersey Chapter of the American Academy of Pediatrics:

Life threatening illness means an illness or condition that requires an immediate response to specific symptoms of sequelae that if left untreated may lead to potential loss of life such as, but not limited to, the use of an inhaler to treat an asthma attack or the use of an adrenaline injection to treat a potential anaphylactic reaction.

**EASTERN CAMDEN COUNTY REGIONAL SCHOOL DISTRICT  
Department of Student Health Services**

PARENT PERMISSION FORM TO SELF MEDICATE  
ASTHMA

Senior High School  
Nurse  
784-4441 x 1136

Intermediate High School  
Nurse  
784-4441 x 1250

To: The Board of Education of Eastern Camden County High School District

From: \_\_\_\_\_

Address: \_\_\_\_\_

Date: \_\_\_\_\_

My son/daughter \_\_\_\_\_

Has my permission to self-administer \_\_\_\_\_.

I acknowledge that the Eastern Camden County Regional School District, its employees and agents shall incur no liability as a result of any injury arising from the self-administration of the above medication. We, the parents of guardians, indemnify and hold harmless the district, its employees and agents against any claims arising out of the self-administration of medication. I/we further acknowledge that my/our child will not give this medication to any other student.

SIGNED\*\* \_\_\_\_\_  
\_\_\_\_\_

\*\*This form is to be signed in the presence of a notary public