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 OF HEALTH SENIOR SERVICES

(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). 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
☐ Ventolin® ☐ Maxair ☐ Xopenex®	2 puffs MDI every 20 minutes
☐ 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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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.

PLEASE READ AND SIGN STATEMENT ON BACK

FAIR HAVEN PUBLIC SCHOOLS

AUTHORIZATION FOR SELF-ADMINISTERED MEDICATION

I have read the Fair Haven Board Policy regarding the self-administration of medication in school. The district and its employees or agents shall incur no liability as a result of any injury arising from the self-administration of medication by my child. I shall indemnify and hold harmless the district and its employees or agents against any claims arising out of the self-administration of medication by my child. I will be responsible for obtaining the prescription and the signed consent from my child's practitioner and for providing the school with an appropriate amount of medication and replacing any expired medication on a timely basis.

I understand this consent is effective for the school year for which it is granted and must be renewed for each subsequent school year.

_____

Parent's/Guardian's Signature

_____

Date

6/05