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 date of birth
   - Child's doctor's name & phone number
   - 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 ____________

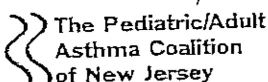
FILL OUT THE SECTION BELOW ONLY IF YOUR HEALTH CARE PROVIDER CHECKED PERMISSION FOR YOUR CHILD TO SELF-ADMINISTER ASTHMA MEDICATION ON THE FRONT OF THIS FORM.

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 ____________



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Sponsored by

Asthma Treatment Plan – Student

(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

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(Please Print)

Name	Date of Birth	Effective Date
Doctor / Phone	Parent/Guardian (if applicable) / Phone	Emergency Contact / 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.

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Advair® HFA ☐ 45, ☐ 115, ☐ 230	2 puffs twice a day
☐ Aerospan™	☐ 1, ☐ 2 puffs twice a day
☐ Alvesco® ☐ 80, ☐ 160	☐ 1, ☐ 2 puffs twice a day
☐ Dulera® ☐ 100, ☐ 200	2 puffs twice a day
☐ Flovent® ☐ 44, ☐ 110, ☐ 220	2 puffs twice a day
☐ Qvar® ☐ 40, ☐ 80	☐ 1, ☐ 2 puffs twice a day
☐ Symbicort® ☐ 80, ☐ 160	☐ 1, ☐ 2 puffs twice a day
☐ Advair Diskus® ☐ 100, ☐ 250, ☐ 500	1 inhalation twice a day
☐ Asmanex® Twisthaler® ☐ 110, ☐ 220	☐ 1, ☐ 2 inhalations ☐ once or ☐ 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® (Budesonide) ☐ 0.25, ☐ 0.5, ☐ 1.0	1 unit nebulized ☐ once or ☐ twice a day
☐ Singulair® (Montelukast) ☐ 4, ☐ 5, ☐ 10 mg	1 tablet daily
☐ Other	
☐ None	

Remember to rinse your mouth after taking inhaled medicine.

If exercise triggers your asthma, take________________ ____ puff(s) ____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).

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	2 puffs every 4 hours as needed
☐ Xopenex®	2 puffs every 4 hours as needed
☐ Albuterol ☐ 1.25, ☐ 2.5 mg	1 unit nebulized every 4 hours as needed
☐ Duoneb®	1 unit nebulized every 4 hours as needed
☐ Xopenex® (Levalbuterol) ☐ 0.31, ☐ 0.63, ☐ 1.25 mg	1 unit nebulized every 4 hours as needed
☐ Combivent Respimat®	1 inhalation 4 times a day
☐ Increase the dose of, or add:	
☐ Other	

- **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!

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	4 puffs every 20 minutes
☐ Xopenex®	4 puffs every 20 minutes
☐ Albuterol ☐ 1.25, ☐ 2.5 mg	1 unit nebulized every 20 minutes
☐ Duoneb®	1 unit nebulized every 20 minutes
☐ Xopenex® (Levalbuterol) ☐ 0.31, ☐ 0.63, ☐ 1.25 mg	1 unit nebulized every 20 minutes
☐ Combivent Respimat®	1 inhalation 4 times a day
☐ Other	

Triggers

Check all items that trigger patient's asthma:

- ☐ Colds/flu
- ☐ Exercise
- ☐ Allergens
  - ○ Dust Mites, dust, stuffed animals, carpet
  - ○ Pollen - trees, grass, weeds
  - ○ Mold
  - ○ Pets - animal dander
  - ○ Pests - rodents, cockroaches
- ☐ Odors (Irritants)
  - ○ Cigarette smoke & second hand smoke
  - ○ Perfumes, cleaning products, scented products
  - ○ Smoke from burning wood, inside or outside
- ☐ Weather
  - ○ Sudden temperature change
  - ○ Extreme weather - hot and cold
  - ○ Ozone alert days
- ☐ Foods:
  - ○ __________
  - ○ __________
  - ○ __________
- ☐ Other:
  - ○ __________
  - ○ __________
  - ○ __________

This asthma treatment plan is meant to assist, not replace, the clinical decision-making required to meet individual patient needs.

Permission to Self-administer Medication:

☐ 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________

Physician's Orders

PARENT/GUARDIAN SIGNATURE________________

PHYSICIAN STAMP

REVISED AUGUST 2014

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Make a copy for parent and for physician file, send original to school nurse or child care provider.

Saint Brendan School
154 East First Street
Clifton, NJ 07011
973-772-1149

Physician's orders for emergency treatment of allergies

Student's Name__________________________________Birth date____________Grade____ID#__________

The above student is allergic to:____

Previous episode of anaphylaxis: (Yes (No

Medications
Antihistamine: Name______________________Dose________________Route________________

Give antihistamine for the following checked symptoms:

☐ Contact with allergen, but no symptoms

☐ Skin-hives, itchy rash, extremity swelling

☐ Lips-itching, tingling, burning, or swelling of lips

☐ Head/neck-swelling of tongue, mouth, or throat, hoarseness, hacking cough, tightening of throat

☐ Gut-abdominal cramps, nausea, vomiting, diarrhea

☐ Lungs-repetitive cough, wheezing, shortness of breath

☐ Heart- thready pulse, low blood pressure, fainting, pale or bluish skin

☐ Other____

****

Epinephrine: ☐ EpiPen (if weight more than 65lbs.) ☐EpiPen, Jr. (if weight up to 65 lbs.) ☐ Other____________
Give epinephrine for the following checked symptoms:

☐ Contact with allergen, but no symptoms

☐ Skin-hives, itchy rash, extremity swelling

☐ Lips-itching, tingling, burning, or swelling of lips

☐ Head/neck-swelling of tongue, mouth, or throat, hoarseness, hacking cough, tightening of throat

☐ Gut-abdominal cramps, nausea, vomiting, diarrhea

☐ Lungs-repetitive cough, wheezing, shortness of breath

☐ Heart- thready pulse, low blood pressure, fainting, pale or bluish skin

☐ Other____

****

Choose one administration order:

Give antihistamine only☐ Give epinephrine only ☐ *Delegate may be assigned, if available

Give antihistamine and epinephrine at the same time ☐ * Delegate may be assigned, if available

Give antihistamine first, observe for further symptoms and give epinephrine PRN ☐

*Please note in the absence of a school nurse, a trained delegate will give epinephrine and any antihistamine order will be disregarded.

****

☐This student (age 8 and above) has been trained and is capable of self-administration of the following medication(s) named above.

☐ Epinephrine-single dose unit ☐ epinephrine & antihistamine-single dose units

☐ This student is not capable of self-administration of the medications named above.

Physician's Signature_______________________________________

Phone number________________Date_______________________Stamp of address

Saint Brendan School

154 East First Street
Clifton, NJ 07011
973-772-1149

Parent form for emergency treatment of allergies

Parents/Guardians

A current single dose Epinephrine auto-injector must be provided to the school for your child's use. All antihistamines and epinephrine must be brought to school by an adult and be provided in the original container. This form must be completed every school year.

Please sign and date.

I verify that my child______________________________ has a potentially life threatening illness and has been instructed in the proper use of the prescribed medication(s), in a life threatening situation. I hereby give permission for my child to adhere to the prescribed medication order. I further acknowledge that St. Brendan School shall incur no liability as a result of any injury arising from the administration of these medication(s) by/to my child. If procedures specified by NJ law and St. Brendan School policy are followed, I shall indemnify and hold harmless St. Brendan School and it's employees or agents against any claims arising out of the administration of medication by/to my child.

______________________________ ________________

Signature of Parent/Guardian Date

If epinephrine is administered, 911 will be called, and one of the contact persons listed below will be notified.

Emergency Contacts (Parents or other person who may be called for my child)

1. Name____________________ Relationship__________ Home Phone__________
   Cell Phone__________
   Work Phone__________
2. Name____________________ Relationship__________ Home Phone__________
   Cell Phone__________
   Work Phone__________

Please read and sign

I understand that under NJ state law, a trained delegate may be assigned to administer epinephrine to my child in the absence of a school nurse.
Antihistamines may not be given by a delegate. In the absence of a school nurse, any antihistamine order will be disregarded and epinephrine will be administered by a trained delegate, if available.

Please indicate if you consent to a trained delegate(s) for your child. (Check One) Yes ☐ No ☐

______________________________ ________________

Signature of Parent/Guardian Date

School Use only

Date____________ ________________________

10/08

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154 East First Street
Clifton, NJ 07011
973-772-1149

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The above student is allergic to:____

Previous episode of anaphylaxis: { Yes { No

Medications
Antihistamine: Name____________________Dose____________Route____________

Give antihistamine for the following checked symptoms:

- ☐Contact with allergen, but no symptoms
- ☐ Skin-hives, itchy rash, extremity swelling
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- ☐ Lungs-repetitive cough, wheezing, shortness of breath
- ☐ Heart- thready pulse, low blood pressure, fainting, pale or bluish skin
- ☐ Other____

****

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- ☐ Other____

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Choose one administration order:

Give antihistamine only☐ Give epinephrine only ☐ *Delegate may be assigned, if available

Give antihistamine and epinephrine at the same time ☐ * Delegate may be assigned, if available

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☐ Epinephrine-single dose unit ☐ epinephrine & antihistamine-single dose units

☐ This student is not capable of self-administration of the medications named above.

Physician's Signature__________________________________

Phone number______________Date____________________Stamp of address