The Pediatric/Adult Asthma Coalition of New Jersey

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

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 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 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.

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AMERICAN LUNG ASSOCIATION® IN NEW JERSEY

Asthma Treatment Plan

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

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(Please Print)

Name	Date of Birth	Effective Date

Doctor	Parent/Guardian (if applicable)	Emergency Contact
Phone	Phone	Phone

HEALTHY

Take daily medicine(s). Some metered dose inhalers may be more effective with a "spacer" – use if directed

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 ________

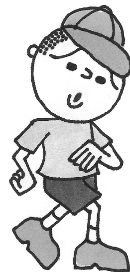
MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Advair® ☐ 100, ☐ 250, ☐ 500 __________	1 inhalation twice a day
☐ Advair® HFA ☐ 45, ☐ 115, ☐ 230________	2 puffs MDI twice a day
☐ Alvesco® ☐ 80, ☐ 160 ________________	☐ 1, ☐ 2 puffs MDI twice a day
☐ Asmanex® Twisthaler® ☐ 110, ☐ 220 ______	☐ 1, ☐ 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

Continue daily medicine(s) and add fast-acting medicine(s).



You have *any* of these:
- Exposure to known trigger
- Cough
- Mild wheeze
- Tight chest
- Coughing at night
- Other:___________

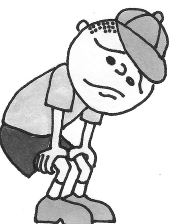
And/or Peak flow from______ to______

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:
  ____
  ____
  ____
  ____
  ____

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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.

WEST WINDSOR-PLAINSBORO REGIONAL SCHOOL DISTRICT

Parent Permission for Administration of Medication in School

Student's Name_____________________________D.O.B.___________ Grade_____

Administration of medication during school hours **is not** encouraged. However, if a physician determines that failure to take medication would jeopardize the health or school attendance of a student, the medication will be given by the school nurse. In so doing, the West Windsor-Plainsboro Board of Education and its employees shall incur no liability for any benefits or consequences occurring from the administration of the medicine.

I hereby request that the school nurse administer __________________________as
Name of Medication

Directed by my physician. I will supply the medication in its original container and personally deliver it to the school nurse.

Medication Information /Adjustments

If this medication is to be given on a regular basis, please indicate what needs to be done if the student is on a class trip or on early closing days. ***Teaching staff can not administer***.

Check One:

_____Student will not be taking the medication when going on a class trip.

_____Administer the medication when the student returns from the class trip.

_____Parent will administer the medication when accompanying student on the trip.

Circle One: **Administer/Do Not Administer** the medication on early closing days.

When applicable and in accordance with the West Windsor-Plainsboro School District's policy, I give permission for my son/daughter to self-administer the above medication. I also understand that the self-administration privilege shall be revoked if it is deemed that my son/daughter has failed to comply with school policy and tenets of the agreement to self-medicate.

I relieve the West Windsor-Plainsboro Board of Education and its employees of any liability for the benefits or consequences arising from the administration or student self-administration of this medication.

____ ____________________

Signature of Parent/Guardian **Date**

____

Parent/Guardian Name (Print/Type/Stamp)