

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



Sponsored by  
**AMERICAN  
LUNG  
ASSOCIATION**  
IN NEW JERSEY



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



- 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® HFA ☐ 45, ☐ 115, ☐ 230 \_\_\_\_\_ 2 puffs twice a day  
☐ Aerospa<sup>TM</sup> \_\_\_\_\_ ☐ 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.**



- 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
<input type="checkbox"/> Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	2 puffs every 4 hours as needed
<input type="checkbox"/> Xopenex®	2 puffs every 4 hours as needed
<input type="checkbox"/> Albuterol <input type="checkbox"/> 1.25, <input type="checkbox"/> 2.5 mg	1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Duoneb®	1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Xopenex® (Levalbuterol) <input type="checkbox"/> 0.31, <input type="checkbox"/> 0.63, <input type="checkbox"/> 1.25 mg	1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Combivent Respimat®	1 inhalation 4 times a day
<input type="checkbox"/> Increase the dose of, or add:	
<input type="checkbox"/> Other	

- **If quick-relief medicine is needed more than 2 times a week, except before exercise, then call your doctor.**



- 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
<input type="checkbox"/> Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	4 puffs every 20 minutes
<input type="checkbox"/> Xopenex®	4 puffs every 20 minutes
<input type="checkbox"/> Albuterol <input type="checkbox"/> 1.25, <input type="checkbox"/> 2.5 mg	1 unit nebulized every 20 minutes
<input type="checkbox"/> Duoneb®	1 unit nebulized every 20 minutes
<input type="checkbox"/> Xopenex® (Levalbuterol) <input type="checkbox"/> 0.31, <input type="checkbox"/> 0.63, <input type="checkbox"/> 1.25 mg	1 unit nebulized every 20 minutes
<input type="checkbox"/> Combivent Respimat®	1 inhalation 4 times a day
<input type="checkbox"/> 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.

[illegible]

The *Prof and Anti-Asthma Coalition* of New Jersey, upon request by the American Lung Association in New Jersey, this publication is approved by a grant from the New Jersey Department of Health and Senior Services, by its approval by the U.S. Center for Disease Control and Prevention on order: Cooperative Agreement U54CE000105-01. Its contents are solely the responsibility of its authors and do not necessarily represent the official views of the New Jersey Department of Health and Senior Services, or the U.S. Center for Disease Control and Prevention. Although this document has been kindly offered as part by the United States Environmental Protection Agency, under agreement UAC9200001-2, to the American Lung Association in New Jersey, it is not published by a U.S. Agency's publications review process and therefore, may not necessarily reflect the views of the Agency and we do not warrant or assume any liability for its content. This publication is not intended to be a diagnosis or health product. It is for informational purposes only and should not be used as a substitute for professional medical advice. It is not intended to be a diagnosis or health product. It is for informational purposes only and should not be used as a substitute for professional medical advice.

**REVISED MAY 2017**

Permission to reproduce blank form • [www.pacnj.org](http://www.pacnj.org)

**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 \_\_\_\_\_ Physician's Orders

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_

PHYSICIAN STAMP

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

# 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 doctor's name & phone number
- Parent/Guardian's name & phone number
- Child's date of birth
- 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 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



# PALMYRA HIGH SCHOOL

311 West Fifth Street

Palmyra, NJ 08065

856-786-9300 | PalmyraSchools.com

## STUDENT MEDICATION PERMISSION FORM

The Palmyra School District requires that:

1. Medication be permitted in school only when failure to take such medicine jeopardizes the health of the student;
2. Written request of the parent/guardian, who shall give permission for the medication AND relieve the school board and its employees of liability for administration of such medication;
3. Written order of the prescribing physician
4. Medication be brought to school and picked up by the parent/guardian. Medications must be in the original container, properly labeled (according to the law) by a pharmacist.

All medication shall normally be administered by the school nurse.

Name of Student \_\_\_\_\_

### -----TO BE COMPLETED BY A PHYSICIAN-----

Name of medication: \_\_\_\_\_

Specific time(s) and Dose(s) to be given at school: \_\_\_\_\_

Length of time medication is prescribed: \_\_\_\_\_

Possible side effects: \_\_\_\_\_

### **Self-administration of medicine shall be limited to the use of inhalers or epipens.**

I hereby certify that this student suffers from \_\_\_\_\_ (a potentially life-threatening condition);  
has been trained in the use of \_\_\_\_\_ (name of inhaler or epipen), and is capable of  
self-administration of the medication for the \_\_\_\_\_ school year.

Printed name of Physician \_\_\_\_\_ Signature of Physician \_\_\_\_\_

Phone \_\_\_\_\_ Date \_\_\_\_\_

### -----TO BE COMPLETED BY PARENT/GUARDIAN-----

I give permission for my child to receive the above medication as directed, and relieve the Palmyra Board of Education and its employees of liability for administration of such medication.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

I am requesting that Palmyra Board of Education give my child permission to carry and use  
\_\_\_\_\_ (name of inhaler/epipen).

I relieve the Palmyra Board of Education and its employees of all liability and will provide an additional inhaler/epipen (identical to the one this child is authorized to carry), which shall be retained by the school nurse.