The Pediatric/Adult Asthma Coalition of New Jersey

"Your Pathway to Asthma Control"
Original 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 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.

The Pediatric/Adult Asthma Coalition of New Jersey, sponsored by the American Lung Association of New Jersey, and this publication are supported by a grant from the New Jersey Department of Health and Senior Services (NJDHSS), with funds provided by the U.S. Centers for Disease Control and Prevention (USCDCP) under Cooperative Agreement 5U59EH000206-2. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the NJDHSS or the USCDCP. Although this document has been funded wholly or in part by the United States Environmental Protection Agency under Agreements XA97256707-1, XA98284401-3 and XA97250908-0 to the American Lung Association of New Jersey, it has not gone through the Agency's publications review process and therefore, may not necessarily reflect the views of the Agency and no official endorsement should be inferred. Information in this publication is not intended to diagnose health problems or take the place of medical advice. For asthma or any medical condition, seek medical advice from your child's or your health care professional.

AMERICAN LUNG ASSOCIATION® *of 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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Sponsored by AMERICAN LUNG ASSOCIATION® of New Jersey

NEW JERSEY DEPARTMENT OF HEALTH and SENIOR SERVICES

(Please Print)

Name	Date of Birth	Effective Date

Doctor Phone	Parent/Guardian (if applicable) Phone	Emergency Contact 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
☐ Advair® 100, 250, 500	1 inhalation twice a day
☐ Advair® HFA 45, 115, 230	2 puffs MDI twice a day
☐ Asmanex® Twisthaler® 110, 220	1 - 2 inhalations a day
☐ Flovent® 44, 110, 220	2 inhalations twice a day
☐ Flovent® Diskus® 50 mcg	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	2 inhalations twice a day
☐ Singulair 4, 5, 10 mg	1 tablet daily
☐ Symbicort® 80, 160	2 puffs MDI twice a day
☐ Other	

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:_____

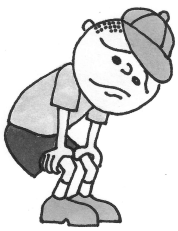
And/or Peak flow from_____ to_____

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:	

➡ **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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EFFECTIVE MARCH 2008

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.

KEARNY PUBLIC SCHOOLS
KEARNY, NJ
MEDICATION PERMISSION

Parental Request

I, _____ request that the medication prescribed by my child's physician be administered to my child by the school nurse at the prescribed time. Also, in the case of an anaphylactic reaction the trained epi-pen designee may administer the prescribed epi-pen. I agree to bring a supply of the medication to the school nurse in its original container upon her request.

_____ _____
Parent's Signature Date

Physician's Statement

In order to protect the health of_____it is necessary for him/ her to have the following medication during school hours.

MEDICATION:

DOSE and ROUTE:

TIME:

SIDE EFFECTS:

PURPOSE:

DIAGNOSIS:

I authorize the school nurse to administer the above medication.

Asthma Inhalers:

Student may_____self administer May not_____self administer

Keep medication in nurse's office_____ Keep medication with student_____

(If child self administers and carries his inhaler he/she must notify nurse when medication is being used so it can be documented. (An additional inhaler should be kept in nurse's office as well).

Signature of physician/stamp_____ Date_____