For children with **asthma**, the following is **required every school year on the first day of school** (total pages including this cover is four):

1. **Asthma Treatment plan** – fill out **completely** with medications needed, triggers, minor section regarding ability to self medicate and **parent and physician signatures.**
2. **Inhaler if applicable** in original, current pharmacy box with pharmacy label
3. **Nebulizer tubing, mouthpiece/mask, and medication** in a current prescription box if applicable (the school has a nebulizer).
4. **School asthma record- Parent** fill out in its entirety (only if your child is a new student) so we have information on your child's condition and return immediately.

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.

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 5U59EH000206-3. 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 Agreement XA97256707-2 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. IN NEW JERSEY

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 AND 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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REVISED MAY 2009

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.

SCHOOL ASTHMA RECORD

Child's Name_____ Date_____

Parent's Name_____ Phone(home)_____

Address_____ Phone(work)_____

Physician Treating Child's Asthma_____ Phone#_____

1. Briefly describe what causes your child's asthma symptoms:_____

_____

2. Does he or she do breathing exercises that are helpful in managing asthma? _____

3. In which sports can the child fully participate?_____

4. Does exercise induce episodes of asthma? If so, list types of exercise._____

_____

5. Do certain weather conditions affect your child's asthma? If so, list them._____

_____

6. Name the medication taken routinely, the dose, how often taken, when, and under what circumstances additional doses should be given_____

_____

7. Does your child experience any side effects to these medications? If so list_____

_____

8. Does your child understand asthma and what he or she should do to manage it?_____

9. How do you want the school to treat an episode of asthma if it should occur?_____

_____

10. Approximately how often does the child have an acute episode?_____

11. If the child does not respond to medication, what action do you advise school personnel to take? _____

_____

12. Does your child need an inhaler for school? No_____ Yes _____ *If yes, please send in the inhaler with the asthma treatment plan signed by parent and physician.*

Comments: _____

_____

Parent/Guardian Signature