**Asthma Treatment Plan – Student**

(Please Print)

**Name**

**Date of Birth**

**Effective Date**

**Doctor**

**Parent/Guardian (if applicable)**

**Emergency Contact**

**Phone**

**Phone**

**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

If you have all of these, you do NOT need an action plan.

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**CAUTION (Yellow Zone) **

You have any of these:

- Cough
- Mild wheeze
- Tight chest
- Coughing at night
- Other: ________________

If you have any of these, you need an action plan.

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**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: ________________

If you are in the emergency zone, call 911 immediately.

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**Take daily control medicine(s). Some inhalers may be more effective with a “spacer” – use if directed.**

<table>
<thead>
<tr>
<th>MEDICINE</th>
<th>HOW MUCH to take and HOW OFTEN to take it</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advair® HFA 45, 115, 230</td>
<td>2 puffs twice a day</td>
</tr>
<tr>
<td>Aerospin®</td>
<td>1, 2 puffs twice a day</td>
</tr>
<tr>
<td>Alvesco® 80, 160</td>
<td>1, 2 puffs twice a day</td>
</tr>
<tr>
<td>Dulera® 100, 200</td>
<td>2 puffs twice a day</td>
</tr>
<tr>
<td>Flovent® 44, 110, 220</td>
<td>2 puffs twice a day</td>
</tr>
<tr>
<td>Qvar® 40, 80</td>
<td>1, 2 puffs twice a day</td>
</tr>
<tr>
<td>Symbicort® 80, 160</td>
<td>1, 2 puffs twice a day</td>
</tr>
<tr>
<td>Advair Diskus® 100, 250, 500</td>
<td>1 inhalation every 20 minutes</td>
</tr>
<tr>
<td>Asmanex® Twiskhale® 110, 220</td>
<td>1, 2 inhalations once or twice a day</td>
</tr>
<tr>
<td>Flovent® Diskus® 50, 100, 250</td>
<td>1 inhalation every 20 minutes</td>
</tr>
<tr>
<td>Pulmicort Flexhaler® 90, 180</td>
<td>1, 2 inhalations once or twice a day</td>
</tr>
<tr>
<td>Pulmicort Respules® (Budesonide)</td>
<td>1 unit nebulized once or twice a day</td>
</tr>
<tr>
<td>Xopenex® (Levalbuterol) 0.25, 0.5, 1.0</td>
<td>1 tablet daily</td>
</tr>
<tr>
<td>Singulair® (Montelukast) 4, 5, 10 mg</td>
<td>1 tablet daily</td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>

And/or Peak flow above __________

*Remember to rinse your mouth after taking inhaled medicine.*

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**Continue daily control medicine(s) and ADD quick-relief medicine(s).**

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<tr>
<td>Albuterol MDI (Pro-air® or Proventil® or Ventolin®) 2 puffs every 4 hours as needed</td>
<td></td>
</tr>
<tr>
<td>Xopenex® 1.25, 2.5 mg</td>
<td>1 unit nebulized every 4 hours as needed</td>
</tr>
<tr>
<td>Duoneb®</td>
<td>1 unit nebulized every 4 hours as needed</td>
</tr>
<tr>
<td>Xopenex® (Levalbuterol) 0.31, 0.63, 1.25 mg</td>
<td>1 unit nebulized every 4 hours as needed</td>
</tr>
<tr>
<td>Combivent Respimat®</td>
<td>1 inhalation every 4 hours as needed</td>
</tr>
</tbody>
</table>

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

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**Take these medicines NOW and CALL 911.**

**Asthma can be a life-threatening illness. Do not wait!**

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**Permission to Self-administer Medication:**

- This student is capable and has been instructed in the proper method of self-administering 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**

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

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**Sponsored by**

- American Lung Association
- NJ Health

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**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 - roaches, 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:
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  - Other:
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- Other:
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- This asthma treatment plan is meant to assist, not replace, the clinical decision-making required to meet individual patient needs.
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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2017-2018 PHYSICIAN/PARENT CERTIFICATION FOR
STUDENT’S SELF-ADMINISTRATION OF MEDICATION

CERTIFICATION TO BE COMPLETED BY PHYSICIAN

STUDENT NAME: __________________________________________

DIAGNOSIS: __________________________________________

NAME OF MEDICATION: __________________________________

DOSAGE: __________________________________________

TIME AND CIRCUMSTANCES OF ADMINISTRATION: __________

POSSIBLE SIDE EFFECTS: ________________________________

I certify that _________________________________ has a potentially life threatening illness
(Student)
which requires the use of _______________________________. I further certify that
(Medication)
____________________________________________________
(Student)
is capable and has been instructed in the proper method of
(self-administration of ________________________________
(Medication)

______________________________  _______________________
Signature of Physician                                      Date

PHYSICIAN NAME: ____________________________________ TELEPHONE #: __________________

******************************************************************************************************************************************

CERTIFICATION TO BE COMPLETED BY PARENT

I hereby authorize my son/daughter ___________________________ to self-administer (Name
of Medication) ____________________________ in accordance with special guidelines.

I acknowledge that the school shall incur no liability as a result of any injury arising from the self-
administration of medication by (student name) _____________________________.

I shall indemnify and hold harmless the school, its employees and agents against any and all claims arising
out of the self-administration of (medication) _____________________________ by
(student name) _____________________________.

______________________________  _______________________
Parent/Guardian Signature                                      Date

SELF-ADMINISTRATION OF MEDICATION IN SCHOOL

Under N.J.S.A. 18A:40-12.3, self-administration of medication by a pupil for asthma or other potentially
life threatening illness is allowed under guidelines established by the school and provided that the statutory
requirements set forth in this form are complied with.

Any permission for the self-administration of medication is effective for this school year only.

N.J.S.A. 18A:40-12.3 PROVIDES THAT THE SCHOOL SHALL INCUR NO LIABILITY AS A
RESULT OF ANY INJURY ARISING FROM THE SELF-ADMINISTRATION OF MEDICATION BY
A STUDENT.

Rev: 4/2015