

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"
Original MDU approved Plan available at
www.aacnj.org

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



(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). All metered dose Inhalers (MDI) to be used with spacers.

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
<input type="checkbox"/> Advair® 100, 250, 500	.....1 inhalation twice a day
<input type="checkbox"/> Advair® HFA 45, 115, 230	.....2 puffs MDI twice a day
<input type="checkbox"/> Asmanex® Twisthaler® 110, 220	..1 - 2 Inhalations a day
<input type="checkbox"/> Flovent® 44, 110, 220	.....2 inhalations twice a day
<input type="checkbox"/> Flovent® Diskus® 50 mcg	.....1 inhalation twice a day
<input type="checkbox"/> Pulmicort Flexhaler® 90, 180	...1 - 2 Inhalations once or twice a day
<input type="checkbox"/> Pulmicort Respules® 0.25, 0.5, 1.0	..1 unit nebulized once or twice a day
<input type="checkbox"/> Qvar® 40, 80	.....2 inhalations twice a day
<input type="checkbox"/> Singulair 4, 5, 10 mg	.....1 tablet daily
<input type="checkbox"/> Symbicort® 80, 160	.....2 puffs MDI twice a day
<input type="checkbox"/> 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
<input type="checkbox"/> Accuneb® 0.63, 1.25 mg	.....1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Albuterol 1.25, 2.5 mg	.....1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Albuterol <input type="checkbox"/> Pro-Air <input type="checkbox"/> Proventil®	..2 puffs MDI every 4 hours as needed
<input type="checkbox"/> Ventolin® <input type="checkbox"/> Maxair <input type="checkbox"/> Xopenex®	..2 puffs MDI every 4 hours as needed
<input type="checkbox"/> Xopenex® 0.31, 0.63, 1.25 mg	..1 unit nebulized every 4 hours as needed
<input type="checkbox"/> 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!

<input type="checkbox"/> Accuneb® 0.63, 1.25 mg	.....1 unit nebulized every 20 minutes
<input type="checkbox"/> Albuterol 1.25, 2.5 mg	.....1 unit nebulized every 20 minutes
<input type="checkbox"/> Albuterol <input type="checkbox"/> Pro-Air <input type="checkbox"/> Proventil®	..2 puffs MDI every 20 minutes
<input type="checkbox"/> Ventolin® <input type="checkbox"/> Maxair <input type="checkbox"/> Xopenex®	..2 puffs MDI every 20 minutes
<input type="checkbox"/> Xopenex® 0.31, 0.63, 1.25 mg	..1 unit nebulized every 20 minutes
<input type="checkbox"/> 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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Approved by the New Jersey Thematic Society

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 N.J. 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.

**KINNELON PUBLIC SCHOOLS
KINNELON, NEW JERSEY 07405**

**AUTHORIZATION FOR SELF-ADMINISTERED ASTHMA/ EMERGENCY
MEDICATION**

STUDENT'S NAME _____ GRADE _____ DOB _____

PARENT'S NAME _____ TELEPHONE (Home) _____
(Work) _____

I give my permission for my child to self-administer the medication described below. I shall indemnify and hold harmless the district and its employees or agents for legal fees, costs and any potential damages concerning self-administration of this medication arising out of any claims brought by the above named child or anyone else.

Parent / Guardian signature

Date

THE FOLLOWING IS TO BE COMPLETED BY THE PHYSICIAN

I am recommending that the above named student be allowed to self-administer the following medication:

Name and purpose of medication _____

Identification of chronic medical problem: _____

Prescribed dosage to be taken: _____

Length of time medication must be taken: _____

Possible side effects and / or special precautions: _____

Conditions under which self-medication will take place:

_____ Independently Child must have had training and be proficient in self-administering medication.

Trainer's Name: _____ Date of Training: _____

_____ Under the supervision of the school nurse.

Medication should be _____ stored in the health office
_____ In the possession of the student

Physician's Signature

Date

Stamp or Type Physician's Name

**KINNELON PUBLIC SCHOOLS
KINNELON, NJ 07405**

James Opiekun
Superintendent of Schools

Richard Maizell, Psy.D
Director of Special Services

INDEMNIFICATION/ HOLD HARMLESS AGREEMENT FOR
SELF – ADMINISTRATION OF MEDICATION

STUDENT'S NAME _____

The parent(s) guardian(s) agree to indemnify, defend and hold the school district harmless from any and all claims, actions, costs, expenses, damages and liabilities, including attorney's fees, arising out of, connected with or resulting from the self-administration of medication by the pupil. The parent(s) guardian(s) agree(s) to extend this indemnification/hold harmless agreement to the Board of Education, Board of Education employees and its agents. The parent(s) guardian(s) agree(s) that the school district, Board of Education, Board of Education employees and its agents shall incur no liability as a result of any injury arising out of or connected with the self-administration of medication by the pupil. Specifically, the parent(s) guardian(s) agree that they will not institute either on their own behalf or on behalf of the pupil, any claim or action against the Board of Education, Board of Education employees and its agents arising out of or connected with self-administration of medication by the pupil.

This agreement shall take effect on the date listed below and shall stay in effect for as long as the pupil is provided permission to self-administer medication. This agreement must be signed and in full effect prior to the granting of permission to self-administer medication.

Parent/Guardian's Name

Parent/Guardian's Signature

Parent/Guardian's Name

Parent/Guardian's Signature

Building Principal Name

Date of Agreement