

"Your Pathway to Asthma Control"  
PACNJ approved Plan available at  
[www.pactnj.org](http://www.pactnj.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.**

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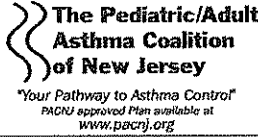
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# Asthma Treatment Plan

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



**(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
<input type="checkbox"/> Advair® <input type="checkbox"/> 100, <input type="checkbox"/> 250, <input type="checkbox"/> 500	_____ 1 inhalation twice a day
<input type="checkbox"/> Advair® HFA <input type="checkbox"/> 45, <input type="checkbox"/> 115, <input type="checkbox"/> 230	_____ 2 puffs MDI twice a day
<input type="checkbox"/> Alvesco® <input type="checkbox"/> 80, <input type="checkbox"/> 160	_____ <input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs MDI twice a day
<input type="checkbox"/> Asmanex® Twisthaler® <input type="checkbox"/> 110, <input type="checkbox"/> 220	_____ <input type="checkbox"/> 1, <input type="checkbox"/> 2 inhalations <input type="checkbox"/> once or <input type="checkbox"/> twice a day
<input type="checkbox"/> Flovent® <input type="checkbox"/> 44, <input type="checkbox"/> 110, <input type="checkbox"/> 220	_____ 2 puffs MDI twice a day
<input type="checkbox"/> Flovent® Diskus® <input type="checkbox"/> 50 <input type="checkbox"/> 100 <input type="checkbox"/> 250	_____ 1 inhalation twice a day
<input type="checkbox"/> Pulmicort Flexhaler® <input type="checkbox"/> 90, <input type="checkbox"/> 180	_____ <input type="checkbox"/> 1, <input type="checkbox"/> 2 inhalations <input type="checkbox"/> once or <input type="checkbox"/> twice a day
<input type="checkbox"/> Pulmicort Respules® <input type="checkbox"/> 0.25, <input type="checkbox"/> 0.5, <input type="checkbox"/> 1.0	_____ 1 unit nebulized <input type="checkbox"/> once or <input type="checkbox"/> twice a day
<input type="checkbox"/> Qvar® <input type="checkbox"/> 40, <input type="checkbox"/> 80	_____ <input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs MDI twice a day
<input type="checkbox"/> Singulair® <input type="checkbox"/> 4, <input type="checkbox"/> 5, <input type="checkbox"/> 10 mg	_____ 1 tablet daily
<input type="checkbox"/> Symbicort® <input type="checkbox"/> 80, <input type="checkbox"/> 160	_____ <input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs MDI twice a day
<input type="checkbox"/> Other	
<input type="checkbox"/> None	

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

If exercise triggers your asthma, take this medicine \_\_\_\_\_ minutes before exercise.

## 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:

## 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® <input type="checkbox"/> 0.63, <input type="checkbox"/> 1.25 mg	_____ 1 unit nebulized 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"/> 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® <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"/> Increase the dose of, or add:	
<input type="checkbox"/> 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!**

<input type="checkbox"/> Accuneb® <input type="checkbox"/> 0.63, <input type="checkbox"/> 1.25 mg	_____ 1 unit nebulized 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"/> 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® <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"/> Other	

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### 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.

**TOWNSHIP OF UNION BOARD OF EDUCATION  
UNION, NEW JERSEY**

Pupil's Name \_\_\_\_\_ School \_\_\_\_\_

Address \_\_\_\_\_ Teacher \_\_\_\_\_

Telephone No. \_\_\_\_\_ Grade \_\_\_\_\_

Description of medication provided by physician \_\_\_\_\_

Diagnosis: \_\_\_\_\_

School nurse is instructed to administer \_\_\_\_\_ in

the following manner \_\_\_\_\_

Medication to be administered from \_\_\_\_\_ to \_\_\_\_\_

**Consideration for Field Trips:**

The above named student may skip the dose of prescribed medication on a field day trip.

The above named student may take the prescribed medication upon returning to school from a field trip.

Date \_\_\_\_\_

(Physician's Signature & Stamp Required)

The school nurse is requested to administer to \_\_\_\_\_

(Child's Name)

the medication prescribed by the above-named physician.

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

The completion of this form is the responsibility of the parent. Upon its completion, it is to be given to the school nurse who will give the medication prescribed. This form will be filed in the office of the school nurse.

**MEDICATION MUST BE BROUGHT TO SCHOOL BY PARENT IN THE  
PRESCRIPTION CONTAINER AND HANDED TO THE NURSE.**

**Washington Elementary School  
Individualized Health Care Plan  
ASTHMA**

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 School/Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_ #: Age when asthma diagnosed: \_\_\_\_\_  
 Doctor: \_\_\_\_\_ Doctor Phone: \_\_\_\_\_ Effective Date: \_\_\_\_\_

List all routine daily medications (name of medication, dose, and times given):

**TRIGGERS:** (Check those which apply to this student)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Exercise                 | <input type="checkbox"/> Emotions (when upset)        | <input type="checkbox"/> cigarette smoke, smog, strong odors (paint, markers, perfumes, sprays) |
| <input type="checkbox"/> Colds (viral illness)    | <input type="checkbox"/> Irritants: Chalk dust, dust, | <input type="checkbox"/> Pollens (trees, grasses, and weeds)                                    |
| <input type="checkbox"/> Weather changes          | <input type="checkbox"/> Molds                        | <input type="checkbox"/> Dust and dust mites  |
| <input type="checkbox"/> Cold air weather changes | <input type="checkbox"/> Animal dander -Type: _____   |   |
| <input type="checkbox"/> Other _____              |   |   |

**SYMPTOMS OF RESPIRATORY DIFFICULTY: any or all of the following**

**INTERVENTION:** Always treat symptoms even if peak flow is not available.

- Coughing      • Chest Tightness      • Shortness of Breath      •Turning Blue      •Wheezing      •Rapid, labored breathing
- Pulling in of skin around neck muscles, above collar bone, between ribs and under breast bone
- Difficulty carrying on a conversation due to difficulty breathing      • Difficulty walking due to breathing problems
- Shallow, rapid breathing      • Blueness (cyanosis) of fingernails and lips      • Decreasing or loss of consciousness
- Other \_\_\_\_\_

Peak flow meter: Yes \_\_\_ No \_\_\_                      Spacer: Yes \_\_\_ No \_\_\_

**CALL 911 IF THE FOLLOWING OCCUR /PERSIST AFTER IMPLEMENTING INTERVENTIONS AS STATED ON THIS ASTHMA HEALTH PLAN**

**Instructions for Staff:**

- Have student stop whatever they are doing
- Send the student to the clinic when experiencing respiratory difficulty as described above

If student has been given permission to self-medicate with their inhaler, allow student to use inhaler according to the following directions:

**Directions for self-medication:**

\_\_\_\_\_ (initial if applicable). Signatures of the parent/guardian and the physician (see reverse side) indicate that both agree the above named student has been instructed on proper use of his/her inhaler and is capable of assuming responsibility for using this medication at his/her discretion. Irresponsible or inappropriate use of the inhaler and/or failure to follow the Health Care Plan by the student will require a reassessment of the permission to self medicate.

Parents/Guardian: _____	
Address: _____	Home Phone: _____ Work Phone: _____
<b>Alternate contacts if parent cannot be reached:</b>	
Name: _____	Name: _____
Home Phone: _____	Home Phone: _____
Work Phone: _____	Work Phone: _____
<b>Physician who should be called regarding asthma:</b>	
Name: _____	
Phone: _____	Fax: _____

- 1) This plan will be reviewed annually and/or whenever the health status or medications change and it is the responsibility of the parent to notify the school nurse of these changes.