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.

Disclaimers:
The use of this Website/PACNJ Asthma Treatment Plan and its content is at your own risk. The content is provided on an "as is" basis. The American Lung Association of the Mid-Atlantic (ALAM-A), the Pediatric/Adult Asthma Coalition of New Jersey and all affiliates disclaim all warranties, express or implied, statutory or otherwise, including but not limited to the implied warranties of merchantability, non-infringement of third parties' rights, and fitness for a particular purpose.

ALAM-A makes no representations or warranties about the accuracy, reliability, completeness, currency, or timeliness of the content. ALAM-A makes no warranty, representation or guaranty that the information will be uninterrupted or error free or that any defects can be corrected.

In no event shall ALAM-A be liable for any damages (including, without limitation, incidental and consequential damages, personal injury/wrongful death, lost profits, or damages resulting from data or business interruption) resulting from the use or inability to use the content of this Asthma Treatment Plan whether based on warranty, contract, tort or any other legal theory, and whether or not ALAM-A is advised of the possibility of such damages. ALAM-A and its affiliates are not liable for any claim, whatsoever, caused by your use or misuse of the Asthma Treatment Plan, nor of this website.

The Pediatric/Adult Asthma Coalition of New Jersey, sponsored by the American Lung Association of New Jersey, and this publication are supported by grants from the New Jersey Department of Health and Senior Services (NJDHSS), with funds provided by the U.S. Centers for Disease Control and Prevention (CDC) under a cooperative agreement (U58/5S00236-3). Its contents are solely the responsibility of the authors and do not necessarily represent the official view of NJDHSS or the CDC. Although this document has been funded wholly or in part by the United States Environmental Protection Agency under Agreement X97525707-1, X97535491-3 and X97535990-0, the American Lung Association of New Jersey, it has not been 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.
Asthma Treatment Plan
(The asthma action plan meets NJ Law N.J.S.A. 18A:46-12.8 (Physician's Orders)
(Please Print)

Name

Date of Birth

Effective Date

Doctor

Parent/Guardian (if applicable)

Emergency Contact

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.

<table>
<thead>
<tr>
<th>MEDICINE</th>
<th>HOW MUCH to take and HOW OFTEN to take it</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advair® 100, 250, 500</td>
<td>1 inhalation twice a day</td>
</tr>
<tr>
<td>Advair® HFA 45, 115, 230</td>
<td>2 puffs MDI twice a day</td>
</tr>
<tr>
<td>Asmanex® Twister® 110, 220</td>
<td>2 inhalations once or twice a day</td>
</tr>
<tr>
<td>Flovent® 44, 110, 220</td>
<td>2 inhalations twice a day</td>
</tr>
<tr>
<td>Flovent® Diskus® 50 mcg</td>
<td>1 inhalation twice a day</td>
</tr>
<tr>
<td>Pulmicort Flexhaler® 90, 180</td>
<td>2 inhalations once or twice a day</td>
</tr>
<tr>
<td>Pulmicort Respules® 0.25, 0.5, 1.0, 1.0 unit nebulized once or twice a day</td>
<td></td>
</tr>
<tr>
<td>Qvar® 40, 80</td>
<td>2 inhalations twice a day</td>
</tr>
<tr>
<td>Singular® 4, 5, 10 mg</td>
<td>1 tablet daily</td>
</tr>
<tr>
<td>Symbicort® 80, 160</td>
<td>2 puffs MDI twice a day</td>
</tr>
</tbody>
</table>
| Other:

And/or Peak flow from

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

Continue daily medicine(s) and add fast-acting medicine(s):

<table>
<thead>
<tr>
<th>MEDICINE</th>
<th>HOW MUCH to take and HOW OFTEN to take it</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accuneb® 0.63, 1.25 mg</td>
<td>1 unit nebulized every 4 hours as needed</td>
</tr>
<tr>
<td>Albuterol 1.25, 2.5 mg</td>
<td>1 unit nebulized every 4 hours as needed</td>
</tr>
<tr>
<td>Albuterol Pro-Air® Proventi®</td>
<td>2 puffs MDI every 4 hours as needed</td>
</tr>
<tr>
<td>Ventolin® Maxair® Xopenex®</td>
<td>2 puffs MDI every 4 hours as needed</td>
</tr>
<tr>
<td>Xopenex® 0.31, 0.63, 1.25 mg</td>
<td>1 unit nebulized every 4 hours as needed</td>
</tr>
</tbody>
</table>

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!

<table>
<thead>
<tr>
<th>MEDICINE</th>
<th>HOW MUCH to take and HOW OFTEN to take it</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accuneb® 0.63, 1.25 mg</td>
<td>1 unit nebulized every 20 minutes</td>
</tr>
<tr>
<td>Albuterol 1.25, 2.5 mg</td>
<td>1 unit nebulized every 20 minutes</td>
</tr>
<tr>
<td>Albuterol Pro-Air® Proventi®</td>
<td>2 puffs MDI every 20 minutes</td>
</tr>
<tr>
<td>Ventolin® Maxair® Xopenex®</td>
<td>2 puffs MDI every 20 minutes</td>
</tr>
<tr>
<td>Xopenex® 0.31, 0.63, 1.25 mg</td>
<td>1 unit nebulized every 20 minutes</td>
</tr>
</tbody>
</table>
| Other:

This asthma treatment plan is meant to assist, not replace, the clinical decision-making required to meet individual patient needs.

FOR MINORS ONLY:
- This student is capable and has been instructed in the proper method of self-administering the inhaled medications named above in accordance with NJ Law.
- This student is not approved to self-medicate.

PHYSICIAN/PATIENT SIGNATURE

DATE

PHYSICIAN STAMP

Make a copy for patient and for physician file. For children under 18, send original to school nurse or child care provider.
FORM 4
STERLING HIGH SCHOOL DISTRICT
501 S. Warwick Road
Somerdale, NJ 08083-2175

PHYSICIAN'S CERTIFICATION for SELF-ADMINISTRATION of MEDICATION by PUPIL for PUPILS with ASTHMA or OTHER POTENTIALLY LIFE-THREATENING ILLNESSES

STUDENT'S NAME: _______________ AGE: _______________ GRADE: _______________

MEDICATION: _______________ Rt of Administration: _______________

DOSEAGE: _______________ FREQUENCY: _______________

POSSIBLE SIDE EFFECTS: _______________

NAME OF ILLNESS/CONDITION: _______________

The minor individual named above is my patient. I understand that this patient is a pupil in your school district.

I further understand that Chapter 308 of the Laws of 1993 allows the parents or guardians of a pupil who has asthma or other potentially life-threatening illness to authorize self-administration of medication by the pupil so long as the pupil's physician certifies to the school district that the pupil is capable of, and has been instructed in, the proper method of self-administration of medication.

My patient suffers from the illness or condition identified above and is required to take the medication also identified above.

My patient is capable of, and has been instructed in, the proper method of self-administration of this medication. In the event that the medication which I have prescribed is changed in the future, I will either assure that my patient remains capable of, and has been instructed in the proper method of self-administration of said medication, or will notify the school district that my patient is no longer capable of, or has not been instructed in, the proper method of such self-administration.

I understand that the authorization by my patient's parents or guardians is effective only for the current school year and must be reauthorized by them for each future school year. Any such reauthorization by my patient's parents or guardians for any future school year must be accompanied by a new certification by me.

__________________________________________  ______________________________________________
Date  PHYSICIAN'S SIGNATURE

__________________________________________  ______________________________________________
Phone #  Print Physician's Name

__________________________________________  ______________________________________________
# Street  Town  State  Zip
STERLING HIGH SCHOOL DISTRICT
501 S. Warwick Road
Somerdale, NJ 08083-2175

PARENT'S AUTHORIZATION for
SELF-ADMINISTRATION of MEDICATION
by PUPIL

STUDENT'S NAME: ___________________ AGE: ______ GRADE: ______

Nature of Illness/Condition: _______________________________

Type of Medication: _______________________________________

We, the undersigned, are the parents/guardians of the pupil named above.

We have been advised by you that legislation has been enacted allowing parents or guardians of a pupil who has asthma or another potentially life-threatening illness to authorize self-administration of medication by the pupil so long as the pupil's physician certifies to you that the pupil is capable of, and has been instructed in, the proper method of self-administration of medication. We have also been advised by you that if we do give this authorization, the school district and its employees and agents will incur no liability as a result of any injury arising from self-administration of medication by the pupil.

The pupil named above suffers from the illness or condition identified and is required to take the stated medication.

We authorize the pupil named above to administer this medication to him/herself while the pupil is under your jurisdiction.

We acknowledge that the school district and its employees and agents shall incur no liability as a result of any injury arising from the self-administration of medication by the pupil and we agree to indemnify and hold harmless the school district and its employees and agents against any claims arising out of the self-administration of medication by the pupil.

We understand that this authorization only applies to this current school year. We have the right to choose whether or not to furnish a new authorization for each future school year.

NOTE: Medications brought to school must be prescription labeled.

PARENT/GUARDIAN* __________________________ DATE ________________

PARENT/GUARDIAN* __________________________ DATE ________________

*In any case involving two parents or more than one guardian, all of the parents and guardians must sign the written authorization.