Asthma Treatment Plan – Student

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

PACNJ Pediatric/Adult Asthma Coalition · Sponsored by American Lung Association in New Jersey · NJ Health New Jersey Department of Health

(Please Print)

Name		Date of Birth	Effective Date
Doctor	Parent/Guardian (if applicable)	Emergency Contact	
Phone	Phone	Phone	

HEALTHY (Green Zone)

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

You have *all* of these:
- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work, exercise, and play

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Advair® HFA ☐ 45, ☐ 115, ☐ 230	2 puffs twice a day
☐ Aerospan™	☐ 1, ☐ 2 puffs twice a day
☐ Alvesco® ☐ 80, ☐ 160	☐ 1, ☐ 2 puffs twice a day
☐ Dulera® ☐ 100, ☐ 200	2 puffs twice a day
☐ Flovent® ☐ 44, ☐ 110, ☐ 220	2 puffs twice a day
☐ Qvar® ☐ 40, ☐ 80	☐ 1, ☐ 2 puffs twice a day
☐ Symbicort® ☐ 80, ☐ 160	☐ 1, ☐ 2 puffs twice a day
☐ Advair Diskus® ☐ 100, ☐ 250, ☐ 500	1 inhalation twice a day
☐ Asmanex® Twisthaler® ☐ 110, ☐ 220	☐ 1, ☐ 2 inhalations ☐ once or ☐ 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® (Budesonide) ☐ 0.25, ☐ 0.5, ☐ 1.0	1 unit nebulized ☐ once or ☐ twice a day
☐ Singulair® (Montelukast) ☐ 4, ☐ 5, ☐ 10 mg	1 tablet daily
☐ Other	
☐ None	

And/or Peak flow above ________

Remember to rinse your mouth after taking inhaled medicine.

If exercise triggers your asthma, take________________ _____ puff(s) ____minutes before exercise.

CAUTION (Yellow Zone)

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

You have *any* of these:
- Cough
- Mild wheeze
- Tight chest
- Coughing at night
- Other:__________

If quick-relief medicine does not help within 15-20 minutes or has been used more than 2 times and symptoms persist, call your doctor or go to the emergency room.

And/or Peak flow from______ to______

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	2 puffs every 4 hours as needed
☐ Xopenex®	2 puffs every 4 hours as needed
☐ Albuterol ☐ 1.25, ☐ 2.5 mg	1 unit nebulized every 4 hours as needed
☐ Duoneb®	1 unit nebulized every 4 hours as needed
☐ Xopenex® (Levalbuterol) ☐ 0.31, ☐ 0.63, ☐ 1.25 mg	1 unit nebulized every 4 hours as needed
☐ Combivent Respimat®	1 inhalation 4 times a day
☐ Increase the dose of, or add:	
☐ Other	

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

EMERGENCY (Red Zone)

Take these medicines NOW and CALL 911.
Asthma can be a life-threatening illness. Do not wait!

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:______________

And/or Peak flow below ________

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	4 puffs every 20 minutes
☐ Xopenex®	4 puffs every 20 minutes
☐ Albuterol ☐ 1.25, ☐ 2.5 mg	1 unit nebulized every 20 minutes
☐ Duoneb®	1 unit nebulized every 20 minutes
☐ Xopenex® (Levalbuterol) ☐ 0.31, ☐ 0.63, ☐ 1.25 mg	1 unit nebulized every 20 minutes
☐ Combivent Respimat®	1 inhalation 4 times a day
☐ Other	

Triggers

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 - rodents, 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:
  - ○ __________
  - ○ __________
  - ○ __________
- ☐ Other:
  - ○ __________
  - ○ __________
  - ○ __________

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

Permission to Self-administer Medication:

☐ 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________

Physician's Orders

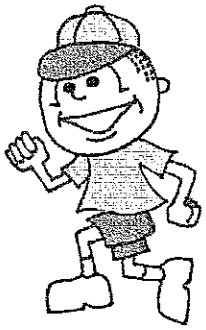
PARENT/GUARDIAN SIGNATURE________________________

PHYSICIAN STAMP

REVISED MAY 2017

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

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 _____

PACNJ Pediatric/Adult Asthma Coalition

The Pediatric/Adult Asthma Coalition of New Jersey, sponsored by the American Lung Association in New Jersey. This publication was supported by a grant from the New Jersey Department of Health and Senior Services, with funds provided by the U.S. Centers for Disease Control and Prevention under Cooperative Agreement SUSIEH000401-5. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the New Jersey Department of Health and Senior Services or the U.S. Centers for Disease Control and Prevention. Although this document has been funded wholly or in part by the United States Environmental Protection Agency under Agreement XA96296601-2 to the American Lung Association in 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.

Sponsored by

AMERICAN LUNG ASSOCIATION® IN NEW JERSEY

School Year: _____

Andover Regional School District Asthma Emergency Care Plan: For Non-Medical Staff of Long Pond School

Parent Completes

Student's Name: _____ DOB: _____ Grade/Teacher: _____

Triggers: _____ Allergies: _____ Weight: _____

Transpo. to/from school - AM: _____ PM: _____ "Aftercare": ❒ N/A ❒ AM ❒ PM

Parent/Guard. 1: _____ Cell: _____ W: _____ H: _____

Parent/Guard. 2: _____ Cell: _____ W: _____ H: _____

Emerg. Cntct. 1: _____ Cell: _____ W: _____ H: _____

Physician Name: _____ Physician Phone: _____

SIGNS OF AN **ASTHMA EMERGENCY** !	**STAFF ACTIONS**	
	...WHEN THE NURSE IS IN BUILDING:	***...IF THE NURSE IS UNAVAILABLE:***
❒ Breathing with chest and/or neck pulled in, sits hunched over, nose opens wide when inhaling. ❒ Difficulty walking and talking ❒ Blue-gray discoloration of lips and/or fingernails. ❒ Symptoms have persisted/ worsened after medication was already given. ❒ Respirations > 30/minute.	• Call the nurse (**x 303**) to come to the student. *State: location, student name, asthma breathing problem.* • Help student assume a comfortable position - sitting up is usually best. • Student breathes in through nose & out through pursed lips slowly/deeply. • Offer student to drink ***warm*** water. • Remain w/ student until nurse arrives	• Call 911, notify Administrator and parent/guardian. • Stay with student until EMS arrives • Sit student up and encourage breathing in through nose & out through pursed lips. • Offer student to drink warm water. • If breathing stops, CPR-certified staff gives CPR until EMS arrives. • *A school staff should go in ambulance if guardian not present.*
SIGNS OF AN ASTHMA EPISODE *(may include some or all)*	**STAFF ACTIONS**	
	...WHEN THE NURSE IS IN BUILDING:	***...IF THE NURSE IS UNAVAILABLE:***
❒ Changes in breathing: coughing, wheezing, breathing through the mouth, shortness of breath. ❒ Verbal reports of: chest tightness, chest pain, cannot catch breath, dry mouth, neck feels funny, doesn't feel well, speaks quietly. ❒ Appears: anxious, sweating, nauseous, fatigued, stands with shoulders hunched over and cannot straighten up easily.	• Stop activity immediately: ***never ask an asthmatic student to wait until the end of a lesson or class.*** • Send student to nurse with a buddy; ***never send student alone!*** • Nurse will assess student and give medication as ordered: _____ • Nurse will observe for relief of symptoms & contact parent and/or call 911 as needed.	• Notify Administrator and parent/guardian. • Parent/guardian (if available) may come to school to administer medication and/or take child home for care. • If parents/guardians and emergency contacts cannot be reached and symptoms persist or worsen, do not hesitate to call 911.

Bus Plan: (1) Pull over, (2) Call 911, (3) Stay with student, (4) Notify School, (5) Notify Parent

TO BE COMPLETED BY NURSE: **Location of medication**: ❒ With student ❒ Nurse office

TO BE COMPLETED BY NURSE: **Is medication needed before Physical Education or recess?**: ❒ Yes ❒ No

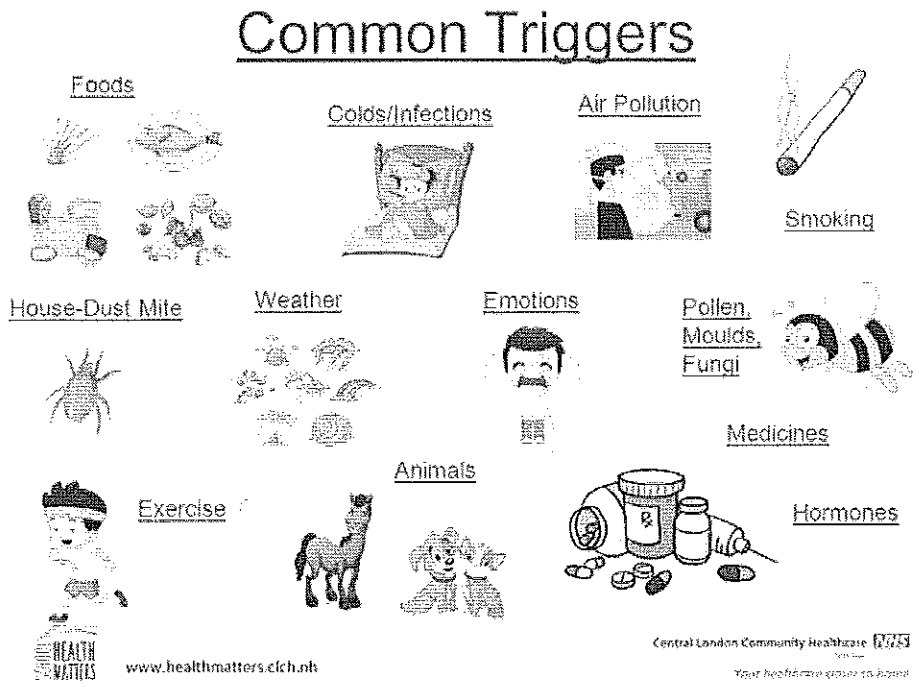
Parent Signature: _____ Date: _____

Nurse Signature: _____ Date: _____

School Year _____

General Prevention Tips:

- Allow student to monitor own activity, ie, rest and slow down as requested, including during PE.
- Reduce known allergens in the classroom to help students who have allergies and asthma. Common allergens found in classrooms are: chalk dust, animals, & strong odors (perfumes, paints).
- Control/cover chemicals and volatile materials used in science, art and other classes.
- Avoid using pens, glue, and paints that emit irritating fumes.
- Plants are sources of mold growth; reduce the quantity of plants in a classroom.
- Do not cover up any vents in the classroom. This prevents fresh air from circulating into the room.



For School Staff: *I acknowledge that I have received a copy of the Asthma ECP for student* _____.
If I am a teacher, I agree to keep a copy of this document in my substitute folder.

Name/Job Title: _____ *Signature:* _____ Date: _____

Name/Job Title: _____ *Signature:* _____ Date: _____

Name/Job Title: _____ *Signature:* _____ Date: _____

Name/Job Title: _____ *Signature:* _____ Date: _____

Name/Job Title: _____ *Signature:* _____ Date: _____

Name/Job Title: _____ *Signature:* _____ Date: _____

Name/Job Title: _____ *Signature:* _____ Date: _____

Name/Job Title: _____ *Signature:* _____ Date: _____

Name/Job Title: _____ *Signature:* _____ Date: _____

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Individualized Healthcare Plan: Asthma (page 1)

PARENT COMPLETES

Student Name: _____ DOB: _____ Class/Grade: _____

Date Diagnosed: _____ Date of Last Attack: _____ ER visits in last yr.: _____ School days missed last yr. due to asthma: _____

Triggers: _____

Symptoms (please ✓): ❑ Coughing ❑ Wheezing ❑ Prolonged expiration ❑ Tightness in chest ❑ Gasping for Air ❑ Skin/lip color changes

What does your child do at home to relieve asthma symptoms? ❑Breathing Exercises ❑Takes Medicine ❑Rest/Relaxation ❑Other: _____

Can your child identify early warning signs & symptoms that indicate onset of an asthma episode & need for quick-relief medicine? _____

Can your child identify asthma symptoms that indicate the need for help or medical attention? _____

TO BE COMPLETED BY SCHOOL NURSE

ASSESSMENT	NURSING DIAGNOSIS	STUDENT GOALS	INTERVENTIONS	STUDENT OUTCOME
Prescribed med(s): _____ _____ _____ _____ *(See Asthma Action Plan for full details.)* BP: _____ Temp: _____ Pulse: _____ Resp: _____	❑ Potential for alteration in respiratory function. ❑ Potential for activity intolerance related to exacerbation of asthma symptoms. ❑ Effective therapeutic regimen management related to: ❑Ability to seek help from others ❑Ability to self-medicate (when appropriate)	❑ Avoid known triggers of asthmatic episodes. ❑Identify symptoms of asthma. ❑Participate in development and implementation of healthcare plan at school. ❑Be safe in all school environments. ❑Know when and how to seek help. ❑Develop self-medication skills when appropriate. ❑Prevent asthmatic symptoms from developing into an emergency.	❑Assess need for, identify and request necessary paperwork and supplies including: Asthma Treatment Plan, Emergency Care Plan, Prescribed medication, Spacer and/or nebulizer tubing. ❑ Assess student's & guardian's knowledge of asthma and mgmt. and educate in asthma, prevention, mgmt. regimen. ❑ Provide safe and proper accessibility to necessary medications during school activities. ❑ Provide necessary health counseling for student to participate in self-care (depending on cognitive and/or physical ability) ❑ Review symptoms & triggers. ❑ Review treatment methods, including how/when to seek assistance from school staff and classmates. ❑ Teach proper technique of self-administration of medication(s) (if indicated by parent & MD). ❑ Monitor school environment for potential	❑ Student will demonstrate signs of good asthma control as evidenced by: ❑ Absent/minimal asthma symptoms. ❑ Full participation in school activities, including sports, recess and play. ❑ Avoidance of school absences, missed time in class and fatigue.. ❑ Minimal reliance on quick-relief medication to control symptoms. ❑ Student will identify his/her symptoms of asthma (from mild to severe) and share information with school

Individualized Healthcare Plan: Asthma (page 2)

			triggers. Notify custodial staff as appropriate. ❑ Maintain current medical orders, consents, release of records and supply of medication. ❑ Ensure all school staff (including bus driver if appropriate) complete asthma in-service. ❑ Field trip/extracurricular activity modifications as needed. ❑ Encourage student to wear identification bracelet/necklace, to be obtained by parent. ❑ Document each asthma episode and severity.	personnel. ❑ Student will actively participate in healthcare management and ECP at school. ❑ Student will understand med administration & return demo (if indicated by parent & MD).

Additional Notes: _____

_____

_____

Parent/Guardian Statement: *I have read this plan and agree to its implementation.*

Parent/Guardian Signature: _____ Date: _____

Student Signature (if age-appropriate): _____ Date: _____

Nurse Signature: _____ Date: _____

Annual IHP Review (for subsequent years):

Parent/Guardian Signature:	Date:	*Parent/Guardian Signature:*	Date:
Student Signature (if age-appropriate):	Date:	*Student Signature (if age-appropriate):*	Date:
Nurse Signature:	Date:	*Nurse Signature:*	Date:
Parent/Guardian Signature:	Date:	*Parent/Guardian Signature:*	Date:
Student Signature (if age-appropriate):	Date:	*Student Signature (if age-appropriate):*	Date:
Nurse Signature:	Date:	*Nurse Signature:*	Date: