

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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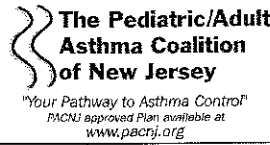
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Asthma Treatment Plan

(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 _____	1, <input type="checkbox"/> 2 puffs MDI twice a day
<input type="checkbox"/> Asmanex® Twisthaler® <input type="checkbox"/> 110, <input type="checkbox"/> 220 _____	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 _____	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 _____	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 _____	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.

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 _____	

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: _____

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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.

**Battle Hill 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: _____
Alternate contacts if parent cannot be reached:	
Name: _____	Name: _____
Home Phone: _____	Home Phone: _____
Work Phone: _____	Work Phone: _____
Physician who should be called regarding asthma:	
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.