Bordentown Regional School District - Asthma Treatment Plan

(Please Print)

Name	Date of Birth	Effective Date

Doctor	Parent/Guardian (if applicable)	Emergency Contact
Phone	**Phone**	**Phone**

HEALTHY (Green Zone)

You have *all* of these:

- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work, exercise, and play

And Peak flow above_____

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

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 puffs ❑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	

CAUTION (Yellow Zone)

You have *all* of these:

- Cough
- Mild wheeze
- Tight chest
- Coughing at night
- Other_____

If quick-relief medicine does not help within15-20 minutes or has been used more than 2 times and symptoms persist, call your doctor or go to the emergency room.

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

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, ❑2.5mg	1 unit nebulized every 4 hours as needed
❑ Duoneb®	1 unit nebulized every 4 hours as needed
❑ Xopenex®(Levalbuterol) ❑0.31, ❑0.63, ❑1.25mg	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)

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

_____

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

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

MORE INFORMATION ON OTHER SIDE

Asthma Treatment Plan – Student

Parent Instructions

The **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 doctor's name & phone number
- Parent/Guardian's name
- Child's date of birth
- An Emergency Contact person's name & phone number & 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 _____