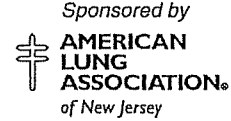
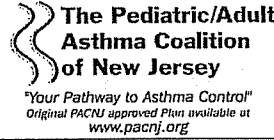


# Asthma Treatment Plan

(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). All metered dose inhalers (MDI) to be used with spacers.**

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
<input type="checkbox"/> Advair® 100, 250, 500	.....1 inhalation twice a day
<input type="checkbox"/> Advair® HFA 45, 115, 230	.....2 puffs MDI twice a day
<input type="checkbox"/> Asmanex® Twisthaler® 110, 220	..1 - 2 inhalations a day
<input type="checkbox"/> Flovent® 44, 110, 220	.....2 inhalations twice a day
<input type="checkbox"/> Flovent® Diskus® 50 mcg	.....1 inhalation twice a day
<input type="checkbox"/> Pulmicort Flexhaler® 90, 180	..1 - 2 inhalations once or twice a day
<input type="checkbox"/> Pulmicort Respules® 0.25, 0.5, 1.0	..1 unit nebulized once or twice a day
<input type="checkbox"/> Qvar® 40, 80	.....2 inhalations twice a day
<input type="checkbox"/> Singulair 4, 5, 10 mg	.....1 tablet daily
<input type="checkbox"/> Symbicort® 80, 160	.....2 puffs MDI twice a day
<input type="checkbox"/> Other	

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® 0.63, 1.25 mg	.....1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Albuterol 1.25, 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® 0.31, 0.63, 1.25 mg	..1 unit nebulized every 4 hours as needed
<input type="checkbox"/> 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!**

- Accuneb® 0.63, 1.25 mg .....1 unit nebulized every 20 minutes
- Albuterol 1.25, 2.5 mg .....1 unit nebulized every 20 minutes
- Albuterol  Pro-Air  Proventil® ..2 puffs MDI every 20 minutes
- Ventolin®  Maxair  Xopenex® ..2 puffs MDI every 20 minutes
- Xopenex® 0.31, 0.63, 1.25 mg ..1 unit nebulized every 20 minutes
- 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: \_\_\_\_\_

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

The Pediatric/Adult Asthma Coalition of New Jersey, sponsored by the American Lung Association of New Jersey and the publication are supported by a grant from the New Jersey Department of Health and Senior Services (NJDHSS), with funds provided by the U.S. Centers for Disease Control and Prevention (US CDC) under Cooperative Agreement #U59CE000662. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the NJDHSS or the US CDCP.

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**EFFECTIVE MARCH 2008**

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### FOR MINORS ONLY:

- This student is capable and has been instructed in the proper method of self-administering of the 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.

## 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.**

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