Asthma Treatment Plan

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

The Pediatric/Adult Asthma Coalition of New Jersey
"Your Pathway to Asthma Control"
Original PACNJ approved Plan available at www.pacnj.org

Sponsored by
AMERICAN LUNG ASSOCIATION® of New Jersey

NEW JERSEY DEPARTMENT OF HEALTH & SENIOR SERVICES

(Please Print)

Name	Date of Birth	Effective Date
Doctor / Phone	Parent/Guardian (if applicable) / Phone	Emergency Contact / 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
☐ Advair® 100, 250, 500	1 inhalation twice a day
☐ Advair® HFA 45, 115, 230	2 puffs MDI twice a day
☐ Asmanex® Twisthaler® 110, 220	1 - 2 inhalations a day
☐ Flovent® 44, 110, 220	2 inhalations twice a day
☐ Flovent® Diskus® 50 mcg	1 inhalation twice a day
☐ Pulmicort Flexhaler® 90, 180	1 - 2 inhalations once or twice a day
☐ Pulmicort Respules® 0.25, 0.5, 1.0	1 unit nebulized once or twice a day
☐ Qvar® 40, 80	2 inhalations twice a day
☐ Singulair 4, 5, 10 mg	1 tablet daily
☐ Symbicort® 80, 160	2 puffs MDI twice a day
☐ 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
☐ Accuneb® 0.63, 1.25 mg	1 unit nebulized every 4 hours as needed
☐ Albuterol 1.25, 2.5 mg	1 unit nebulized every 4 hours as needed
☐ Albuterol ☐ Pro-Air ☐ Proventil®	2 puffs MDI every 4 hours as needed
☐ Ventolin® ☐ Maxair ☐ Xopenex®	2 puffs MDI every 4 hours as needed
☐ Xopenex® 0.31, 0.63, 1.25 mg	1 unit nebulized every 4 hours as needed
☐ 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 this 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 (USCDCP) under Cooperative Agreement 5U-9ISH 000206-2. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the NJDHSS or the USCDCP.

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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.

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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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