

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



(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



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.

And/or Peak flow above _____

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.

CAUTION



You have **any** of these:

- Exposure to known trigger
- Cough
- Mild wheeze
- Tight chest
- Coughing at night
- Other: _____



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.

And/or Peak flow from _____ to _____

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



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

<input type="checkbox"/> Accuneb® 0.63, 1.25 mg . . . . .	.1 unit nebulized every 20 minutes
<input type="checkbox"/> Albuterol 1.25, 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® 0.31, 0.63, 1.25 mg . . .	.1 unit nebulized every 20 minutes
<input type="checkbox"/> Other	

And/or Peak flow below _____

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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