Asthma Action Plan for Student-Home & SchooL

NJ Law N.J.S.A. 18A:40-12.8 (Healthcare Provider's Order)

Parent/Guardian fill out TOP, and SIGN at bottom of form!
Healthcare Provider fill out REMAINDER, and SIGN & STAMP at bottom of form!

Students Name:	DOB:	Effective Date:
Parent/Guardian Emergency Contact:	Phone:	Phone:
Healthcare Provider:	Phone:	Fax:

HEALTHY - Green Zone>>>>>>>>>>>>>>>>>>>>>>>>
You have all of these:

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

***If exercise triggers asthma, take__puffs___before exercise!**

***Use spacer as directed & rinse mouth after use!**

CAUTION - Yellow Zone>>>>>>>>>>>>>>>>>>>>>>>>
May have any of these:

- Some problems breathing
- Cough/Wheeze
- Tight chest
- Problems working or playing
- Awake at night
- Other:_____

***If quick relief medicine does not help within 15-20 minutes or has been used more than 2 x's & symptoms persist, call HCP or go the ER.**

EMERGENCY - Red Zone>>>>>>>>>>>>>>>>>>>>>>>>
Asthma is getting worse fast:

- Quick relief medication 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:_____

***Take daily Control Medications.**

Medication-How Much to take & how Often

__Advair HFA __45__115_230>>>__2 puffs 2x daily
__Aerospan>>>>>>>>>>>>>>1 puff__2 puffs 2x daily
__Alvesco__80__160>>>>__1 puff__2 puffs
__Dulera__100__200>>>>>>>>>>>>>2 puffs 2x daily
__Flovent__44__110__220->>>>>>> 2 puffs 2x daily
__Qvar__40__80>>>>>>>>>1 puff__2 puffs 2x daily
__Symbicort__80__160>>>> 1 puff__2 puffs 2x daily
__Advair Diskus__100__250__500>> 1 inhalation 2x daily
__Asmanex Twisthaler_110_220>>>>>1 inhalation__2 inhalations__1x daily__2x daily__Flovent Diskus_50_100_250>>>>>>1 inhalation 2x daily
__Pulmicort Flexhaler__90__180>>>__1 inhalation__2 inhalations__1x daily__2x daily
__Pulmicort Respules__0.25__0.5__1.0>> 1 unit nebulized__1x daily__2x daily
__Singulair (Montelukast)__4__5__10>> 1 tablet daily
__Other__None
_____

Medication-How Much to take & how Often

__Albuterol MDI (Pro-air or Proventil or Ventolin) 2 puffs every 4 hrs. as needed__Xopenex 2 puffs every 4 hrs. as needed __Albuterol__1.25__2.5 - 1 unit nebulized unit every 4 hrs. as needed__Duoneb 1 unit nebulized every 4 hrs. as needed __Xopenex (Levalbuterol) __0.31__0.63__1.25 - 1 unit nebulized every 4 hrs. as needed__Combivent Respimat - 1 inhalation 4x daily__Increase the dose of or add_____
__Other_____

***If quick relief medication is needed more than 2 x a week, except before exercise, call your Healthcare Provider.**

***Take these medications NOW and CALL 911**
Asthma can be a life-threatening illness, so do not wait!

__Albuterol MDI (Pro-air, or Proventi or Ventolin)__4 puffs every 20 minutes__Xopenex 4 puffs every 20 minutes __Albuterol __1.25__2.5 - 1 unit nebulized every 20 minutes__Duoneb - 1 unit nebulized every 20 minutes__Xopenex__0.31__0.63__1.25 - 1 unit nebulized every 20 minutes__Combivent Respimat - 1 inhalation 4x daily__Other_____

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, or carry.

***Make copy for Parent/Guardian, send original to School Nurse!**

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 & 2nd hand smoke
- Perfumes, cleaning products, scented products
- Smoke from burning inside or outside smoke

~Weather
- Sudden temperature change
- Extreme weather – hot & cold
- Ozone alert days

~Foods:
- _____
- _____
- _____

~Other:
- _____
- _____
- _____

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

Healthcare Provider's ***Signature*** **& STAMP**

_____

I give permission for the medication listed in this Asthma Action Plan to be administered to my child during the school day, school sponsored trips/activities, by the school nurse, or other staff deemed appropriate, if needed. I give permission for the school nurse to share pertinent health information regarding my child with essential school personnel, emergency contacts, prescribing healthcare provider, and school physician, if needed. I acknowledge that the school nurse and staff shall incur no liability because of any condition arising from decisions made on behalf of my child, and in the best interest of my child's health and welfare. I indemnify and hold the school, school nurse, its employees, and agents harmless against claims arising from the decisions made on behalf of my child and in the best interest of my child's health and welfare.

Parent/Guardian
*Signature:*_____