HASBROUCK HEIGHTS PUBLIC SCHOOL
SCHOOL HEALTH SERVICES

ASTHMA PACK

TO BE COMPLETED BY THE PARENT & DOCTOR

Physician's Order for Medication

Asthma Treatment Plan

Lincoln School
Kimberly Kane, RN
(201) 393-8184 office
(201) 393-0365 fax

HS/MS
Mary Neumann, RN
(201) 393-8160 office
(201) 393-8948 fax

Euclid School
Jolanta Czajkowski, RN
(201) 393-8178 office
(201) 288-0753

HASBROUCK HEIGHTS BOARD OF EDUCATION **(DOCTOR/PARENT)**
Hasbrouck Heights, New Jersey 07604 File Code: 5141.21
Exhibit

PHYSICIAN'S ORDER
FOR THE ADMINISTRATION OF MEDICATION IN SCHOOL

STUDENT'S NAME_____ DOB_____ GRADE_____

NAME OF DRUG_____

DOSAGE_____ TIME(S) TO BE ADMINISTERED_____

DIAGNOSIS / REASON FOR MEDICATION_____

POSSIBLE SIDE EFFECTS _____

DURATION OF USE_____

PHYSICIAN'S SIGNATURE_____ DATE_____

PLEASE PRINT OR STAMP:
PHYSICIAN'S NAME ADDRESS
PHONE NUMBER

PARENT AUTHORIZATION
FOR THE ADMINISTRATION OF MEDICATION IN SCHOOL

I request that the above medication, in the original container, be administered to my child. I understand that a certified school nurse or her designated nurse substitute will be performing this service utilizing the order provided by my physician. I acknowledge that the school district and its employees and agents shall incur no liability as a result of administration of this medication to my child. I give the school nurse permission to contact the physician and / or pharmacist with any question concerning the medication.

PARENT / GUARDIAN'S SIGNATURE_____ DATE_____

HOME PHONE_____ WORK / CELL PHONE_____

INITIAL MEDICATION SUPPLY:

Name of medicine_____# of pills/tablets/capsules/ml._____

Nurse signature _____***Parent signature***_____

STUDENT'S NAME_____ DOB_____ GRADE_____

MEDICATION SUPPLY RECORD:

DATE	MEDICINE	#	PARENT SIGNATURE	NURSE SIGNATURE

The Pediatric/Adult Asthma Coalition of New Jersey

"Your Pathway to Asthma Control"

Original PACNJ approved Plan available at www.pacnj.org

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.

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 5U59EH000206-2. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the NJDHSS or the USCDCP. Although this document has been funded wholly or in part by the United States Environmental Protection Agency under Agreements XA97256707-1, XA98284401-3 and XA97250908-0 to the American Lung Association of New Jersey, it has not gone through the Agency's publications review process and therefore, may not necessarily reflect the views of the Agency and no official endorsement should be inferred. Information in this publication is not intended to diagnose health problems or take the place of medical advice. For asthma or any medical condition, seek medical advice from your child's or your health care professional.

AMERICAN LUNG ASSOCIATION® of New Jersey

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 AND SENIOR SERVICES

(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
O Advair ® 100, 250, 500	.1 inhalation twice a day
O Advair ® HFA 45, 115, 230	.2 puffs MDI twice a day
O Asmanex® Twisthaler® 110, 220	.1 - 2 inhalations a day
O Flovent ® 44, 110, 220	.2 inhalations twice a day
O Flovent ® Diskus® 50 mcg	.1 inhalation twice a day
O Pulmicort Flexhaler® 90, 180	.1 - 2 inhalations once or twice a day
O Pulmicort Respules® 0.25, 0.5, 1.0	.1 unit nebulized once or twice a day
O Qvar ® 40, 80	.2 inhalations twice a day
O Singulair 4, 5, 10 mg	.1 tablet daily
O Symbicort® 80, 160	.2 puffs MDI twice a day
O 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
O Accuneb® 0.63, 1.25 mg	.1 unit nebulized every 4 hours as needed
O Albuterol 1.25, 2.5 mg	.1 unit nebulized every 4 hours as needed
O Albuterol O Pro-Air O Proventil®	.2 puffs MDI every 4 hours as needed
O Ventolin® O Maxair O Xopenex®	.2 puffs MDI every 4 hours as needed
O Xopenex® 0.31, 0.63, 1.25 mg	.1 unit nebulized every 4 hours as needed
O 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!

O Accuneb® 0.63, 1.25 mg	.1 unit nebulized every 20 minutes
O Albuterol 1.25, 2.5 mg	.1 unit nebulized every 20 minutes
O Albuterol O Pro-Air O Proventil®	.2 puffs MDI every 20 minutes
O Ventolin® O Maxair O Xopenex®	2 puffs MDI every 20 minutes
O Xopenex® 0.31, 0.63, 1.25 mg	.1 unit nebulized every 20 minutes
O 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
- ❑ Plants, flowers, dander
- ❑ cut grass, pollen
- ❑ Strong odors, perfumes, cleaning products, scented products
- ❑ Sudden temperature change
- ❑ Wood Smoke
- ❑ Foods:

_____

_____

_____

- ❑ Other:

_____

_____

_____

_____

_____

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EFFECTIVE MARCH 2008

FOR MINORS ONLY:

O 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.

O This student is not approved to self-medicate.

PHYSICIAN/APN/PASIGNATURE _____ DATE _____

PARENT/GUARDIANSIGNATURE _____

PHYSICIAN STAMP

Make a copy for patient and for physician file. For children under 18, send original to school nurse or child care provider.