HASBROUCK HEIGHTS PUBLIC SCHOOL SCHOOL HEALTH SERVICES

ASTHMA PACK

TO BE COMPLETED BY THE PARENT & DOCTOR Physician's Order for Medication Asthma Treatment Plan

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Hasbrouck Heights, New Jersey 07604 File Code: 5141.21
Exhibit

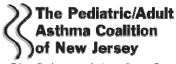
PHYSICIAN'S ORDER FOR THE ADMINISTRATION OF MEDICATION IN SCHOOL

STUDENT'S NAME	DOB	GRADE	
NAME OF DRUG			<u> </u>
DOSAGE1	OSAGETIME(S) TO BE ADMINISTERED		
DIAGNOSIS / REASON FOR MED	ICATION		_
POSSIBLE SIDE EFFECTS			_
DURATION OF USE			_
DUVELCIANIE CIONATUDI	-	DATE	
PHYSICIAN'S SIGNATURI	=	DATE	
PLEASE PRINT OR STAMP: PHYSICIAN'S NAME		PHONE NUMBER	ADDRESS
FOR THE	PARENT AUTHO ADMINISTRATION OF		N SCHOOL
certified school nurse or her desi by my physician. I acknowledge	gnated nurse substitute will that the school district and edication to my child. I give	be performing this its employees and the school nurse performing this is the school nurse performing the school nurse performing this is the school nurse performing the school nurse performing this is the school nurse performing the school nurse performance performing the school nurse performance performing the school nurse performance perf	d to my child. I understand that a service utilizing the order provided agents shall incur no liability as a ermission to contact the physician
PARENT / GUARDIAN'S			
SIGNATURE		DATE	
HOME PHONE	WORK / CELL P	HONE	
INITIAL MEDICATION SUPPLY	<u>:</u>		
Name of medicine	# of pills/tablets/	capsules/ml	

Nurse signature ______Parent signature_____

DATE	MEDIONIE		DADENT GLONATURE	NUIDOE OLONIATURE
DATE	MEDICINE	#	PARENT SIGNATURE	NURSE SIGNATURE

STUDENT'S NAME______ DOB_____ GRADE____



"Your Pathway to Asthma Control" Original PACNI expressed 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

Parent/Guardian's name & phone number

- · Patient's date of birth
- Patient's doctor'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
- <u>ForMinorsOnly</u> 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

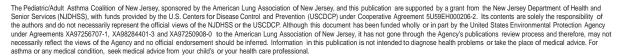
This Asthma Treatment Plan is meant to assist, not replace, the clinical decision-making required to meet individual patient needs. Not all asthma medications are listed and the generic names are not listed.

Disclaimers:

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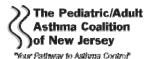
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Asthma Treatment Plan







Triggers

Check all items

that trigger patient's asthma:

& second hand

☐ Chalk dust ☐ Cigarette Smoke

smoke ☐ Colds/Flu ■ Dust mites. dust, stuffed animals, carpet ■ Exercise ■ Mold

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

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Name		Date of Birth		Effective Date
Doctor	Parent/Guardian (if applicable)		Emergency Contact	
Phone	Phone		Phone	

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п	EA		•



Take daily medicine(s). All metered dose inhalers (MDI) to be used with spacers.

You have all of these:

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

MEDICINE	HOW MUCH to take and HOW OFTEN to take i
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
	01 unit nebulized once or twice a day
0 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	

And/or Peak flow above

Remember to rinse your mouth after taking inhaled medicine.

If exercise triggers your asthma, take this medicine minutes before exercise.

cockroaches ☐ Pets - animal

☐ Plants, flowers,

dander

Ozone alert days

☐ Pests - rodents &

cut grass, pollen ☐ Strong odors,

perfumes, clean-

scented products

ing products,

□ Sudden tempera-

ture change

■ Wood Smoke

■ Foods:

Other:

CAUTION



You have any of these:

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

MEDICINE

HOWMUCHtotakeandHOWOFTENtotakeit

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

Continue daily medicine(s) and add fast-acting medicine(s).

- 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.

And/or Peak flow from



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!

- 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

This asthma treatment plan is meant to assist, not replace, the clinical decisionmaking required to meet individual

patient needs.

And/or Peak flow below

The Pediatric/Add Ashma Coalition of New Jessey, sponsored by the American Lung Association of New Jessey, and this publication are supported by again from the New Jessey Supported of Health and Sonic Services (NLDHSS), with fursity provided by the U.S. Cortes for Disease Control and Phenevision (USCDOP-for Comparison (SUSPER) (DOCS)—2. Its contents are solely the re-sponsibility of the authors and do not necessarily represent the official views of the UNHSS or the USCDOP.

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 <u>not</u> approved to self-medicate.

PHYSICIAN/APN/PASIGNATURE

PHYSICIAN STAMP

PARENT/GUARDIANSIGNATURE



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