

# **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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**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

PHONE NUMBER

ADDRESS

**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 \_\_\_\_\_

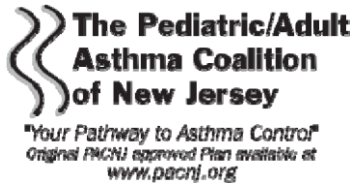
**INITIAL MEDICATION SUPPLY:**

Name of medicine \_\_\_\_\_ # of pills/tablets/capsules/ml. \_\_\_\_\_

Nurse signature \_\_\_\_\_ **Parent signature** \_\_\_\_\_

STUDENT'S NAME \_\_\_\_\_ DOB \_\_\_\_\_ GRADE \_\_\_\_\_

**MEDICATION SUPPLY RECORD:**[illegible]

## 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      • An Emergency Contact person's name & phone number
- Patient's doctor'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.

#### Disclaimers:

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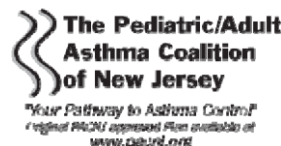
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# Asthma Treatment Plan

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



(Please Print)

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



**HEALTHY** 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
0 Advair <sup>®</sup> 100, 250, 500 . . . . .	1 inhalation twice a day
0 Advair <sup>®</sup> HFA 45, 115, 230 . . . . .	2 puffs MDI twice a day
0 Asmanex <sup>®</sup> Twisthaler <sup>®</sup> 110, 220 . . .	1 - 2 inhalations a day
0 Flovent <sup>®</sup> 44, 110, 220 . . . . .	2 inhalations twice a day
0 Flovent <sup>®</sup> Diskus <sup>®</sup> 50 mcg . . . . .	1 inhalation twice a day
0 Pulmicort Flexhaler <sup>®</sup> 90, 180 . . . .	1 - 2 inhalations once or twice a day
0 Pulmicort Respules <sup>®</sup> 0.25, 0.5, 1.0..	1 unit nebulized once or twice a day
0 Qvar <sup>®</sup> 40, 80 . . . . .	2 inhalations twice a day
0 Singulair 4, 5, 10 mg . . . . .	1 tablet daily
0 Symbicort <sup>®</sup> 80, 160 . . . . .	2 puffs MDI twice a day
0 Other	



hand

You have all of these:

Triggers

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

Check all items that trigger asthma: the

- Cigarette smoke
- Colds/Flu

And/or Peak flow above \_\_\_\_\_

- Dust mites, dust, stuffed animals, carpet
- Exercise
- Mold

Remember to rinse your mouth after taking inhaled medicine.

- Pests - rodents & cockroaches
- Pets - animal



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

\_\_\_\_\_ minutes

- Plants, flowers, dander

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
0 Accuneb® 0.63, 1.25 mg . . . . .	.1 unit nebulized every 4 hours as needed 0 Albuterol 1.25, 2.5 mg . . . . .
0 Albuterol 0 Pro-Air 0 Proventil	.2 puffs MDI every 4 hours as needed 0 Ventolin® 0 Maxair 0 Xopenex® .2 puffs MDI every 4 hours as needed 0 Xopenex® 0.31, 0.63, 1.25 mg . . .1 unit nebulized every 4 hours as needed 0
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.	

- Ozone alert

days cut grass,

pollen

- Strong odors, perfumes, cleaning products, scented products
- Sudden temperature change
- Wood Smoke

- Foods:

Other: \_\_\_\_\_

# 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!**

- 0 Accuneb® 0.63, 1.25 mg . . . . .1 unit nebulized every 20 minutes 0
- Albuterol 1.25, 2.5 mg . . . . .1 unit nebulized every 20 minutes
- 0 Albuterol 0 Pro-Air 0 Proventil® .2 puffs MDI every 20 minutes
- 0 Ventolin® 0 Maxair 0 Xopenex® 2 puffs MDI every 20 minutes
- 0 Xopenex® 0.31, 0.63, 1.25 mg . .1 unit nebulized every 20 minutes
- 0 Other

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**EFFECTIVE  
MARCH 2008**

**FOR MINORS ONLY:**

0 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.

0 This student is not approved to self-medicate.

PHYSICIAN/APN/PASIGNATURE

PARENT/GUARDIANSIGNATURE

PHYSICIAN STAMP

DATE \_\_\_\_\_



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