

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

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
<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.

CAUTION



You have any of these:

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

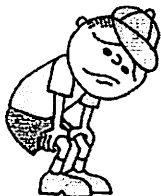
And/or Peak flow from _____ to _____

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

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
<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.

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!

<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	

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.

The Pediatric/Adult Asthma Coalition of New Jersey, sponsored by the American Lung Association of New Jersey, and this publication are provided by a grant from the New Jersey Department of Health and Senior Services (NJHSS), with funds provided by the U.S. Centers for Disease Control and Prevention (CDC) in accordance with Cooperative Agreement 5U49CE000205-01. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the CDC or the NJHSS.

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FOR MINORS ONLY:

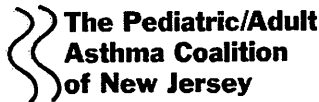
- This student is capable and has been instructed in the proper method of self-administering of the inhaled medications named above in accordance with NJ Law.
- This student is not approved to self-medicate.

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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