**Asthma Action Plan for Student at Home & SchooL**

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

**Parent/Guardian:** Please fill out *TOP TWO ROWS* & *SIGN* bottom right!

**Healthcare Provider (HCP):** Pleasefill out all *BOXES, CHECK/CIRCLE* what isApplicable to Student then *SIGN* & *STAMP* bottom right! Please provide a *COPY* to Parent/Guardian & School Nurse!!

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| --- | --- | --- |
| Students Name: | DOB: | Effective Date: |
| Parent/Guardian Emergency Contact: | Phone: | Phone: |
| **HCP** (***fills out everything below***): | Phone: | Fax: |
| Green HEALTHY Zone- You have all of these symptoms:   * 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!  -----------------------------------------------  Yellow CAUTION Zone-You may have some of these symptoms:   * Some problems breathing * Cough/Wheeze * Tight chest * Problems working or playing * Awake at night * **HCP** Other:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**   **\***If quick relief medicine does not help within 15-20 minutes & symptoms persist, call HCP or go the ER.  -----------------------------------------------  Red DANGER 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 * **HCP** Other:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | HEALTHY > Maintenance Meds - Amount, Dosage & Frequency:  Advair Diskus**\_**100**\_**250**\_**500 \_\_1 puff\_\_1x daily\_\_2 puffs\_\_2x daily  Advair HFA **\_\_**45**\_\_**115\_\_230 \_\_1 puff\_\_1x daily**\_\_**2 puffs\_\_2x daily  Aerospan \_**\_**1 puff**\_\_**1x daily**\_\_**2 puffs\_\_2x daily  Alvesco**\_\_**80**\_\_**60 **\_\_**1 puff\_\_1x daily\_\_2 puffs\_\_2x daily  Asmanex Twisthaler**\_**110**\_**220 \_\_1 puff**\_\_**1x daily**\_\_**2 puffs\_\_2x daily  Dulera**\_\_**100**\_\_**200 \_\_1 puff\_\_1x daily\_\_2 puffs\_\_2x daily  Flovent**\_\_**44**\_\_**110**\_\_**220 \_\_1 puff**\_\_**1x daily\_\_2 puffs\_\_2x daily  Flovent Diskus**\_**50**\_**100**\_**250 \_\_1 puff\_\_1x daily\_\_2 puffs\_\_2x daily  Pulmicort Flexhaler**\_**90**\_**180 \_\_1 puff**\_\_**1x daily\_\_2 puffs**\_\_**2x daily  Pulmicort Respules**\_**0.25**\_**0.5**\_**1.0\_\_1 unit nebulized**\_\_**1x daily or  **\_\_**2x daily  Qvar**\_\_**40**\_\_**80 \_\_1 puff**\_\_**1x daily\_\_2 puffs\_\_2x daily  Singulair (Montelukast)**\_\_**4**\_\_**5**\_\_**10 **\_\_**1 tab \_\_1x daily  Symbicort\_**\_**80**\_\_**160 \_\_1 puff**\_\_**1x daily**\_\_**2 puffs\_\_2x daily  Other**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  None\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  --------------------------------------------------------------------  CAUTION > Rescue Meds - Amount, Dosage & Frequency:  Albuterol**\_\_**1.25**\_\_**2.5 \_\_1 unit nebulized every\_\_4 hrs. as needed  Albuterol MDI (Pro-air or Proventil or Ventolin) \_\_2 puffs every\_\_4 hrs. as needed  Combivent Respimat\_\_1 puff\_\_4x daily, \_\_or increase the dose to\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, or add**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Duoneb \_\_1 unit nebulized every\_\_4 hrs. as needed  Xopenex \_\_2 puffs every\_\_4 hrs. as needed  Xopenex (Levalbuterol) **\_**0.31**\_**0.63**\_**1.25\_\_1 unit nebulized every  \_\_4 hrs. as needed  Othe**r\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  \*If quick relief medication is needed more than 2 x a week, except before exercise, call your Healthcare Provider.  --------------------------------------------------------------------  DANGER > EMERGENCY Meds - Take these NOW & call 911; Asthma can be life-threatening, do NOT wait!  Albuterol \_\_1.25\_\_2.5 \_\_1 unit nebulized every\_\_20 minutes  Albuterol MDI (Pro-air, or Proventi or Ventolin) \_\_4 puffs every\_\_20 minutes  Combivent Respimat \_\_1 puff\_\_4x daily  Duoneb \_\_1 unit nebulized every\_\_20 minutes  Xopenex \_\_4 puffs every\_\_20 minutes  Xopenex\_\_0.31\_\_0.63\_\_1.25 \_\_1 unit nebulized every\_\_20 minutes  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **--------------------------------------------------------------------**  After discussion between Parent/Guardian & HCP , the HCP checks below what is applicable to Student:  **\_\_**This student **IS CAPABLE** & approved to self-medicateand carry his/her inhaler as he/she has been instructed in the proper method of self-administering the non-nebulized inhaled medications named above in accordance with NJ Law.  **\_\_**This student **IS NOT CAPABLE**, approved to self-medicate, or carry his/her inhaler.  **\*HCP** **please make copy for Parent/Guardian & School Nurse!** | TRIGGERS – **HCP** Check/Circle what is Applicable to Student:  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.  *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** *SIGN* Here*:*  **X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **HCP** *SIGN* & *STAMP* Here:  **X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

*Revised Asthma Action Plan from* [*www.panj.org*](http://www.panj.org)*, sponsored by American Lung Association & NJDOH, CPS ES/HS/MS, Updated 10/25/23, SLR, Updated 5/21/24 SLR. Revised GPSD-Bowe 9/2/24, SLR*