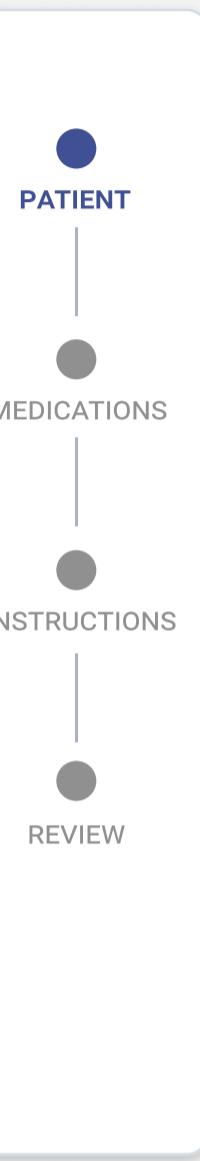


Asthma Treatment Plan - Student

[edit title](#)

Patient Information

Name:**Date of Birth** mm dd yyyy**Effective Date** mm/dd/yyyy **Doctor****Telephone****Parent/Guardian****Telephone****Emergency Contact****Telephone**

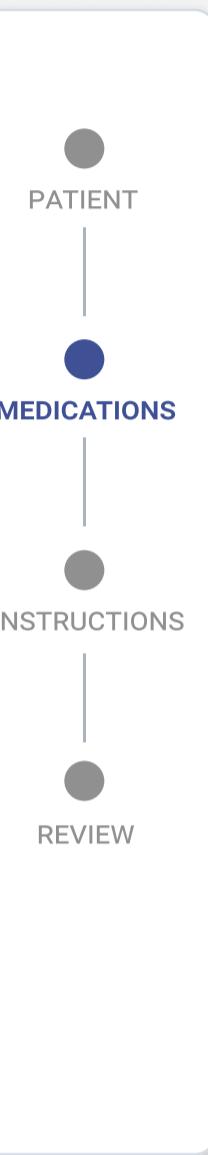
Medications

Fill out health details below.

HEALTHY (Green Zone)**CAUTION (Yellow Zone)****EMERGENCY (Red Zone)**

Medications

Fill out health details below.



HEALTHY (Green Zone)



Take daily control medicine(s). Some inhalers may be more effective with a "spacer" – use if directed.

-Visual Graphics WIP-

Medicine #1
Placeholder

Amount
mcg

How Often
times a day

Medicine #2
Placeholder

Amount
mcg

How Often
times a day

Add Medication

CAUTION (Yellow Zone)



EMERGENCY (Red Zone)



TRIGGERS

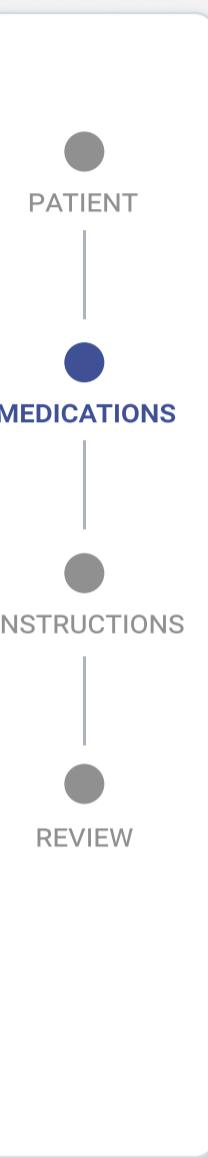


PERMISSION



Medications

Fill out health details below.



HEALTHY (Green Zone)



CAUTION (Yellow Zone)



EMERGENCY (Red Zone)



TRIGGERS



Check all items that trigger patient's asthma:

- 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 & second hand smoke
 - Perfumes, cleaning products, scented products
 - Smoke from burning wood, inside or outside
- Weather
 - Sudden temperature change
 - Extreme weather - hot and cold
 - Ozone alert days

Foods:

- _____
- _____
- _____
- _____

Other:

- _____
- _____
- _____
- _____

Notes:

This asthma treatment plan is meant to assist, not replace, the clinical decision-making required to meet individual patient needs.

PERMISSION



Instructions



Include additional details if needed.

Parent Instructions

[edit title](#)

The **PACNJ Asthma Treatment Plan** is designed to help everyone understand the steps necessary for the individual student to achieve the goal of controlled asthma.

1. **Parents/Guardians:** Before taking this form to your Health Care Provider, complete the top left section with:
 - Child's name
 - Child's doctor's name & phone number
 - Parent/Guardian's name & phone number
 - Child's date of birth
 - 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 check 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 your child to follow
3. **Parents/Guardians & Health Care Providers together** will discuss and then complete the following areas:
 - Child's peak flow range in the Healthy, Caution and Emergency sections on the left side of the form
 - Child's asthma triggers on the right side of the form
 - Permission to Self-administer Medication 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

[edit](#)[Generate Form](#)

Review

- PATIENT
- MEDICATIONS
- INSTRUCTIONS
- REVIEW

Asthma Treatment Plan – Student

(This Asthma Action Plan Meets NJ Law N.J.S.A. 18A:40-12.8) (Physician's Orders)



-INSERT PATIENT INFORMATION-

-Form layout WIP-

