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

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 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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Asthma Treatment Plan
(Please Print)

Name

Date of Birth

Effective Date

Doctor

Parent/Guardian (if applicable)

Emergency Contact

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). Some metered dose inhalers may be more effective with a “spacer” – use if directed

<table>
<thead>
<tr>
<th>MEDICINE</th>
<th>HOW MUCH to take and HOW OFTEN to take it</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advair® 100, 250, 500</td>
<td>1 inhalation twice a day</td>
</tr>
<tr>
<td>Advair® HFA 45, 115, 230</td>
<td>2 puffs MDI twice a day</td>
</tr>
<tr>
<td>Alvesco® 80, 160</td>
<td>1, 2 puffs MDI twice a day</td>
</tr>
<tr>
<td>Asmanex® Twisthaler® 110, 220</td>
<td>1, 2 inhalations once or twice a day</td>
</tr>
<tr>
<td>Flovent® 44, 110, 220</td>
<td>2 puffs MDI twice a day</td>
</tr>
<tr>
<td>Flovent® Diskus® 50, 100, 250</td>
<td>1 inhalation twice a day</td>
</tr>
<tr>
<td>Pulmicort Flexhaler®90, 180</td>
<td>1, 2 inhalations once or twice a day</td>
</tr>
<tr>
<td>Pulmicort Respules® 0.25, 0.5, 1.0</td>
<td>1 unit nebulized once or twice a day</td>
</tr>
<tr>
<td>Ovar® 40, 80</td>
<td>1, 2 puffs MDI twice a day</td>
</tr>
<tr>
<td>Singular® 4, 5, 10 mg</td>
<td>1 tablet daily</td>
</tr>
<tr>
<td>Symbicort® 80, 160</td>
<td>1, 2 puffs MDI twice a day</td>
</tr>
<tr>
<td>Other</td>
<td>None</td>
</tr>
</tbody>
</table>

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).

<table>
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<tr>
<th>MEDICINE</th>
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<tr>
<td>Accuneb® 0.63, 1.25 mg</td>
<td>1 unit nebulized every 4 hours as needed</td>
</tr>
<tr>
<td>Albuterol 1.25, 2.5 mg</td>
<td>1 unit nebulized every 4 hours as needed</td>
</tr>
<tr>
<td>Albuterol Pro-Air® Proventil® 2 puffs MDI every 4 hours as needed</td>
<td></td>
</tr>
<tr>
<td>Ventolin® Maxair® Xopenex® 2 puffs MDI every 4 hours as needed</td>
<td></td>
</tr>
<tr>
<td>Xopenex® 0.31, 0.63, 1.25 mg</td>
<td>1 unit nebulized every 4 hours as needed</td>
</tr>
<tr>
<td>Increase the dose of, or add:</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

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!

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<td>Other</td>
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FOR MINORS ONLY:
- This student is capable and has been instructed in the proper method of self-administering the non-nebulized inhaled medications named above in accordance with N.J. Law.
- This student is not approved to self-medicate.

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

PHYSICIAN/APN/PA SIGNATURE ___________________________ DATE __________

PARENT/GUARDIAN SIGNATURE ___________________________

PHYSICIAN STAMP ___________________________

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