**Take daily control medicine(s). Some 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® HFA □ 45, □ 115, □ 230</td>
<td>2 puffs twice a day</td>
</tr>
<tr>
<td>Aerospan™ □</td>
<td>1, □ 2 puffs twice a day</td>
</tr>
<tr>
<td>Alvesco® □ 80, □ 160</td>
<td>2 puffs twice a day</td>
</tr>
<tr>
<td>Dulera® □ 100, □ 200</td>
<td>2 puffs twice a day</td>
</tr>
<tr>
<td>Flovent® □ 44, □ 110, □ 220</td>
<td>2 puffs twice a day</td>
</tr>
<tr>
<td>Qvar® □ 40, □ 80</td>
<td>1, □ 2 puffs twice a day</td>
</tr>
<tr>
<td>Symbicort® □ 80, □ 160</td>
<td>1, □ 2 puffs twice a day</td>
</tr>
<tr>
<td>Advair Diskus® □ 100, □ 250, □ 500</td>
<td>1 inhalation twice a day</td>
</tr>
<tr>
<td>Asmanex® Twinhaler® □ 110, □ 220</td>
<td>□ 1, □ 2 inhalations □ once or □ 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® (Budesonide) 0.25, □ 0.5, □ 1.0</td>
<td>1 unit nebulized □ once or □ twice a day</td>
</tr>
<tr>
<td>Singulair® (Montelukast) □ 4, □ 5, □ 10 mg</td>
<td>1 tablet daily</td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

**If exercise triggers your asthma, take** ____________ puff(s) ____________ minutes before exercise.

**Remember to rinse your mouth after taking inhaled medicine.**

**Continue daily control medicine(s) and ADD quick-relief medicine(s).**

<table>
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<tr>
<th>MEDICINE</th>
<th>HOW MUCH to take and HOW OFTEN to take it</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albuterol MDI (Pro-air® or Proventil® or Ventolin®) □ 2 puffs every 4 hours as needed</td>
<td></td>
</tr>
<tr>
<td>Xopenex® □</td>
<td>2 puffs 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>Duoneb® □</td>
<td>1 unit nebulized every 4 hours as needed</td>
</tr>
<tr>
<td>Xopenex® (Levalbuterol) □ 0.31, □ 0.63, □ 1.25 mg</td>
<td>1 unit nebulized every 4 hours as needed</td>
</tr>
<tr>
<td>Combivent Respinimat® □</td>
<td>1 inhalation 4 times a day</td>
</tr>
</tbody>
</table>

**Increase the dose of, or add:**

- **Other:**

**If quick-relief medicine is needed more than 2 times a week, except before exercise, then call your doctor.**

**Take these medicines NOW and CALL 911.**

**Asthma can be a life-threatening illness. Do not wait!**

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<tr>
<td>Albuterol MDI (Pro-air® or Proventil® or Ventolin®) □ 4 puffs every 20 minutes</td>
<td></td>
</tr>
<tr>
<td>Xopenex® □</td>
<td>4 puffs every 20 minutes</td>
</tr>
<tr>
<td>Albuterol □ 1.25, □ 2.5 mg</td>
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</tbody>
</table>

**Emergency (Red Zone)!!!**

**Your asthma is getting worse fast:**

- Quick-relief medicine 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
- Other:

**And/or Peak flow below** ____________

**Healthy (Green Zone)!!!**

**You have all of these:**

- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work, exercise, and play

**Remember to rinse your mouth after taking inhaled medicine.**

**Caution (Yellow Zone)!!!**

**You have any of these:**

- Cough
- Mild wheeze
- Tight chest
- Coughing at night
- Other:

**If quick-relief medicine does not help within 15-20 minutes or has been used more than 2 times and symptoms persist, call your doctor or go to the emergency room.**

**And/or Peak flow from to** ____________

**Permission to Self-administer Medication:**

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

**Make a copy for parent and for physician file, send original to school nurse or child care provider.**
Asthma Treatment Plan – Student

Parent Instructions

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 date of birth
   - An Emergency Contact person’s name & phone number
   - Parent/Guardian’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 asthmatic 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

PARENT AUTHORIZATION

I hereby give permission for my child to receive medication at school as prescribed in the Asthma Treatment Plan. Medication must be provided in its original prescription container properly labeled by a pharmacist or physician. I also give permission for the release and exchange of information between the school nurse and my child’s health care provider concerning my child’s health and medications. In addition, I understand that this information will be shared with school staff on a need to know basis.

Parent/Guardian Signature
Phone
Date

FILL OUT THE SECTION BELOW ONLY IF YOUR HEALTH CARE PROVIDER CHECKED PERMISSION FOR YOUR CHILD TO SELF-ADMINISTER ASTHMA MEDICATION ON THE FRONT OF THIS FORM.

RECOMMENDATIONS ARE EFFECTIVE FOR ONE (1) SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY

☐ I do request that my child be ALLOWED to carry the following medication __________________________ for self-administration in school pursuant to N.J.A.C.:6A:16-2.3. I give permission for my child to self-administer medication, as prescribed in this Asthma Treatment Plan for the current school year as I consider him/her to be responsible and capable of transporting, storing and self-administration of the medication. Medication must be kept in its original prescription container. I understand that the school district, agents and its employees shall incur no liability as a result of any condition or injury arising from the self-administration by the student of the medication prescribed on this form. I indemnify and hold harmless the School District, its agents and employees against any claims arising out of self-administration or lack of administration of this medication by the student.

☐ I DO NOT request that my child self-administer his/her asthma medication.

Parent/Guardian Signature
Phone
Date

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