Medication Self-Administration Form for Asthma

This form must be completed and signed by the child's physician prior to the medication's use in school. The student is to have an inhaler in their possession, an extra inhaler may be provided to the school nurse.

Student's name _____ DOB _____

Building _____ Grade _____ Teacher _____

Diagnosis _____

Medication _____

Dosage, Route and Time of Administration _____

_____

Possible Side Effects _____

It is essential to this child's health that this medication be administered immediately upon presentation of symptoms. When the School Nurse is present, she/he may assist in the medication's administration. I understand that a nurse may not be immediately available at all times and that the child may be required to self-administer the medication. I have instructed this child in the proper procedure for administration and find him/her competent to self-administer the above named medication.

Physician's Name _____ **Signature** _____ **Date** _____

I request that my child be permitted to carry and self administer the medication listed above. I have observed the child's technique in self-administering this medication and feel he/she is competent to do so. In signing this form I release school personnel from all liability related to administration of the medication.

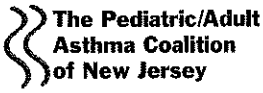
Parent's Name _____ **Signature** _____ **Date** _____

On this date of _____ I observed the child's ability to self-administer the medication stated above.

Nurse's Name _____ **Signature** _____ **Date** _____

Asthma Treatment Plan

(This asthma action plan meets NJ Law N.J.S.A. 18A:40-12.8) (Physician's Orders)



"Your Pathway to Asthma Control"
PACNJ approved Plan available at www.pacnj.org

Sponsored by

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

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Advair® ☐ 100, ☐ 250, ☐ 500	_____1 inhalation twice a day
☐ Advair® HFA ☐ 45, ☐ 115, ☐ 230	_____2 puffs MDI twice a day
☐ Alvesco® ☐ 80, ☐ 160	_____☐ 1 ☐ 2 puffs MDI twice a day
☐ Asmanex® Twisthaler® ☐ 110, ☐ 220	_____☐ 1 ☐ 2 inhalations ☐ once ☐ twice a day
☐ Flovent® ☐ 44, ☐ 110, ☐ 220	_____2 puffs MDI twice a day
☐ Flovent® Diskus® ☐ 50 ☐ 100 ☐ 250	_____1 inhalation twice a day
☐ Pulmicort Flexhaler® ☐ 90, ☐ 180	_____☐ 1 ☐ 2 inhalations ☐ once ☐ twice a day
☐ Pulmicort Respules® ☐ 0.25, ☐ 0.5, ☐ 1.0	__1 unit nebulized ☐ once ☐ twice a day
☐ Qvar® ☐ 40, ☐ 80	_____☐ 1 ☐ 2 puffs MDI twice a day
☐ Singulair ☐ 4, ☐ 5, ☐ 10 mg	_____1 tablet daily
☐ Symbicort® ☐ 80, ☐ 160	_____☐ 1 ☐ 2 puffs MDI twice a day
☐ Other	
☐ None	

Remember to rinse your mouth after taking inhaled medicine.

If exercise triggers your asthma, take this medicine_____ ____minutes before exercise.

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: _____ _____ _____ _____ _____

CAUTION

You have *any* of these:
- Exposure to known trigger
- Cough
- Mild wheeze
- Tight chest
- Coughing at night
- Other:_____

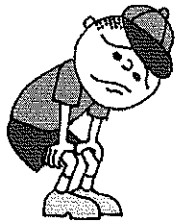
And/or Peak flow from_____ to_____

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

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Accuneb® ☐ 0.63, ☐ 1.25 mg	_____1 unit nebulized every 4 hours as needed
☐ Albuterol ☐ 1.25, ☐ 2.5 mg	_____1 unit nebulized every 4 hours as needed
☐ Albuterol ☐ Pro-Air ☐ Proventil®	_____2 puffs MDI every 4 hours as needed
☐ Ventolin® ☐ Maxair ☐ Xopenex®	_____2 puffs MDI every 4 hours as needed
☐ Xopenex® ☐ 0.31, ☐ 0.63, ☐ 1.25 mg	__1 unit nebulized every 4 hours as needed
☐ Increase the dose of, or add:	
☐ Other	

➡ **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!

☐ Accuneb® ☐ 0.63, ☐ 1.25 mg	_____1 unit nebulized every 20 minutes
☐ Albuterol ☐ 1.25, ☐ 2.5 mg	_____1 unit nebulized every 20 minutes
☐ Albuterol ☐ Pro-Air ☐ Proventil®	_____2 puffs MDI every 20 minutes
☐ Ventolin® ☐ Maxair ☐ Xopenex®	_____2 puffs MDI every 20 minutes
☐ Xopenex® ☐ 0.31, ☐ 0.63, ☐ 1.25 mg	__1 unit nebulized every 20 minutes
☐ Other	

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

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FOR MINORS ONLY:

☐ 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.

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.