Dear Parent/Guardian,

Due to the COVID-19 pandemic, there will be a temporary change to the protocol for albuterol or levalbuterol administration within the school setting. COVID-19 germs are spread through the air when an infected person coughs, sneezes, talks, or breathes. Some medical procedures, such as nebulizer treatments, increase the risk of spreading the germs farther within a room. This could place students and staff at higher risk for exposure to COVID-19 infection.

*During this COVID-19 pandemic, the CDC recommends:*

- Asthma treatments using inhalers with spacers, with or without face mask, according to each student's individualized treatment plan are **preferred over nebulizer treatments whenever possible.**

Nebulizer treatments at school should be reserved for children who cannot use or do not have access to an inhaler (with or without spacer or face mask).

We ask that you discuss your child's Asthma Treatment Plan for the 20-21 school year with your physician keeping the following in mind:

1. There will temporarily be **very limited** use of nebulizers in the health office.

2. Parents should supply an Inhaler with an appropriate sized spacer if recommended by their child's MD. If you are unable to obtain a spacer, please contact the school nurse.

3. Each school will have an albuterol inhaler in lieu of the nebulizer solution from previous years to be used during emergency symptoms of students with active Asthma Action Plans who do not have their own medication supply.

4. Each school will have a limited supply of spacers and masks for use in emergency situations.

5. For severe emergencies, stock epinephrine via auto-injector will be used and 911 will be called.

   [Signature]

   Dr. Thomas Sargent

   8/13/2020

   Date
### Asthma Treatment Plan – Student

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

**(Please Print)**

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Birth</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent/Guardian (if applicable)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phone</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### HEALTHY (Green Zone)

**You have all of these:**
- Breathing is good
- No cough or wheezing
- Sleep through the night
- Can work, exercise, and play

And/or Peak flow above _______

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

**CAUTION (Yellow Zone)**

**You have any of these:**
- Cough
- Mild wheezing
- 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 ______

### 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 ______

### 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>1, □ 2 puffs twice a day</td>
</tr>
<tr>
<td>Bucerol® □ 100, □ 200</td>
<td>2 puffs twice a day</td>
</tr>
<tr>
<td>Flovent® □ 44, □ 110, □ 220</td>
<td>1, □ 2 puffs twice a day</td>
</tr>
<tr>
<td>Vanceril® □ 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® TwiThaler® □ 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>
<tr>
<td>None</td>
<td>□ □ □ □ □ □ □ □</td>
</tr>
</tbody>
</table>

**Take these medicines NOW and CALL 911. Asthma can be a life-threatening illness. Do not wait!**

<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>4 puffs every 20 minutes</td>
</tr>
<tr>
<td>Xopenex®</td>
<td>4 puffs every 20 minutes</td>
</tr>
<tr>
<td>Albuterol MDI (Pro-air® or Proventil® or Ventolin®)</td>
<td>2 puffs every 4 hours as needed</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>Combidex® (Fluticasone)</td>
<td>□ 1 unit nebulized every 4 hours as needed</td>
</tr>
<tr>
<td>Combidex® (Fluticasone)</td>
<td>□ 1 inhalation 4 times a day</td>
</tr>
<tr>
<td>Increase the dose of, or add:</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>□ □ □ □ □ □ □ □</td>
</tr>
</tbody>
</table>

**Triggers**

Check all items that trigger patient’s asthma:
- Colds/Flu
- Exercise
- Allergies
  - Dust Mite, dust, stuffed animals, carpet
  - Pollen - trees, grass, weeds
  - Mold
  - Pets - animal dander
  - Pests - roaches, 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: ____________________________

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

### 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.

### Physician’s Orders

**PHYSICIAN/APN/PA SIGNATURE_________**

**DATE_________**

**PARENT/GUARDIAN SIGNATURE_________**

**PHYSICIAN STAMP_________**

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
   - Child’s doctor’s name & phone number
   - 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 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

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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