

UNIVERSAL CHILD HEALTH RECORD

*Endorsed by: American Academy of Pediatrics, New Jersey Chapter
New Jersey Academy of Family Physicians
New Jersey Department of Health and Senior Services*

SECTION I - TO BE COMPLETED BY PARENT(S)					
Child's Name (Last) _____ (First) _____		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth _____ / _____ / _____	
Does Child Have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Name of Child's Health Insurance Carrier _____			
Parent/Guardian Name _____		Home Telephone Number _____		Work Telephone/Cell Phone Number _____	
Parent/Guardian Name _____		Home Telephone Number _____		Work Telephone/Cell Phone Number _____	
<i>I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.</i>					
Signature/Date _____				This form may be released to WIC. <input type="checkbox"/> Yes <input type="checkbox"/> No	
SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER					
Date of Physical Examination: _____		Results of physical examination normal? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Abnormalities Noted: 		Weight (must be taken within 30 days for WIC)		_____	
		Height (must be taken within 30 days for WIC)		_____	
		Head Circumference (if <2 Years)		_____	
		Blood Pressure (if ≥3 Years)		_____	
IMMUNIZATIONS		<input type="checkbox"/> Immunization Record Attached <input type="checkbox"/> Date Next Immunization Due: _____			
MEDICAL CONDITIONS					
Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments _____	
Medications/Treatments • List medications/treatments:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments _____	
Limitations to Physical Activity • List limitations/special considerations:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments _____	
Special Equipment Needs • List items necessary for daily activities		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments _____	
Allergies/Sensitivities • List allergies:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments _____	
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments _____	
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments _____	
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments _____	
PREVENTIVE HEALTH SCREENINGS					
Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note If Abnormal
Hgb/Hct			Hearing		
Lead: <input type="checkbox"/> Capillary <input type="checkbox"/> Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		
<input type="checkbox"/> <i>I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.</i>					
Name of Health Care Provider (Print) _____			Health Care Provider Stamp _____		
Signature/Date _____					

Instructions for Completing the Universal Child Health Record (CH-14)

Section 1 - Parent

Please have the parent/guardian complete the top section and sign the consent for the child care provider/school nurse to discuss any information on this form with the health care provider.

The WIC box needs to be checked only if this form is being sent to the WIC office. WIC is a supplemental nutrition program for Women, Infants and Children that provides nutritious foods, nutrition counseling, health care referrals and breast feeding support to income eligible families. For more information about WIC in your area call 1-800-328-3838.

Section 2 - Health Care Provider

1. Please enter the date of the physical exam that is being used to complete the form. Note significant abnormalities especially if the child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing etc.)

- **Weight** - Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within the last 30 days.
- **Height** - Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within the last 30 days.
- **Head Circumference** - Only enter if the child is less than 2 years.
- **Blood Pressure** - Only enter if the child is 3 years or older.

2. **Immunization** - A copy of an immunization record may be copied and attached. If you need a blank form on which to enter the immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Department of Health and Senior Services, Immunization Program at 609-588-7512.

- The Immunization record must be attached for the form to be valid.
- "Date next immunization is due" is optional but helps child care providers to assure that children in their care are up-to-date with immunizations.

3. **Medical Conditions** - Please list any ongoing medical conditions that might impact the child's health and well being in the child care or school setting.

- a. Note any significant medical conditions or major surgical history. If the child has a complex medical condition, a special care plan should be completed and attached for any of the medical issue blocks that follow. A generic care plan (CH-15) can be downloaded at www.state.nj.us/health/forms/ch-15.dot or pdf. Hard copies of the CH-15 can be requested from the Division of Family Health Services at 609-292-5666.

- b. **Medications** - List any ongoing medications. Include any medications given at home if they might impact the child's health while in child care (seizure, cardiac or asthma medications, etc.). Short-term medications such as antibiotics do not need to be listed on this form. Long-term antibiotics such as antibiotics for urinary tract infections or sickle cell prophylaxis should be included.

PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigger medication administration.

Please be specific about what over-the-counter (OTC) medications you recommend, and include information for the parent and child care provider as to dosage, route, frequency, and possible side effects. Many child care providers may require separate permissions slips for prescription and OTC medications.

- c. **Limitations to physical activity** - Please be as specific as possible and include dates of limitation as appropriate. Any limitation to field trips should be noted. Note any special considerations such as avoiding sun exposure or exposure to allergens. Potential severe reaction to insect stings should be noted. Special considerations such as back-only sleeping for infants should be noted.
 - d. **Special Equipment** - Enter if the child wears glasses, orthodontic devices, orthotics, or other special equipment. Children with complex equipment needs should have a care plan.
 - e. **Allergies/Sensitivities** - Children with life-threatening allergies should have a special care plan. Severe allergic reactions to animals or foods (wheezing etc.) should be noted. Pediatric asthma action plans can be obtained from The Pediatric Asthma Coalition of New Jersey at www.pacrj.org or by phone at 908-687-9340.
 - f. **Special Diets** - Any special diet and/or supplements that are medically indicated should be included. Exclusive breastfeeding should be noted.
 - g. **Behavioral/Mental Health Issues** - Please note any significant behavioral problems or mental health diagnoses such as autism, breath holding, or ADHD.
 - h. **Emergency Plans** - May require a special care plan if interventions are complex. Be specific about signs and symptoms to watch for. Use simple language and avoid the use of complex medical terms.
4. **Screening** - This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public health personnel to track children's health. Please enter the date that the test was performed. Note if the test was abnormal or place an "N" if it was normal.
 - For lead screening state if the blood sample was capillary or venous and the value of the test performed.
 - For PPD enter millimeters of induration, and the date listed should be the date read. If a chest x-ray was done, record results.
 - Scoliosis screenings are done biennially in the public schools beginning at age 10.
- This form may be used for clearance for sports or physical education. As such, please check the box above the signature line and make any appropriate notations in the Limitation to Physical Activities block.
5. Please sign and date the form with the date the form was completed (note the date of the exam, if different)
 - Print the health care provider's name.
 - Stamp with health care site's name, address and phone number.

**Daisy Recreation Program
(732) 390-6797**

**Physician's Instructions for
Administration of Medication at the Daisy Recreation Program**

To be completed by Physician:

Physician: Please be aware that our nurse is only able to administer the medication you are authorizing at lunch time (Approximately 11:30AM - 12:15PM)

Participant Name _____
Address _____

Date of Order	Name of Medication	Dose	Instructions

Physician's Name _____
Address _____
Phone # _____ Fax # _____
Physician's Signature _____ Date _____

H:\My Documents\DAISYForms\Authorization for admin of Meds - Physician.wpd

Revised 07-08-10

Physician's Office Stamp Required
↓



Township of East Brunswick

**DIVISION OF RECREATION
AND COMMUNITY SERVICES**

Daisy Recreation Program (732) 390-6797

Authorization for Administration of Medication

To Parents/Guardians:

Administrative policy of the East Brunswick Division of Recreation requires the nurse to have the written permission of a participant's parent/guardian in order to administer a prescribed medication during the program day.

No other medication other than that prescribed by your physician will be administered. Medication can only be administered at approximately lunch time.

The participant's physician must fill out and sign the reverse side of this page, the Physician's Instructions for Administration of Medication at the Daisy Recreation Program, and by doing so, provide written authorization for the nurse to administer the medication.

The medication must be given to the nurse in a pharmacy labeled container which includes the name and telephone number of the pharmacy, the prescription number, the child's name, directions for administering the medication, and the name of the physician prescribing the medication. Medication not in containers labeled as above will not be administered.

Parent/Guardian: Please complete and sign below to authorize the Daisy Recreation program nurse to administer the medication prescribed by your child's physician:

I authorize the Daisy Recreation program nurse to administer medication to:

_____, as prescribed by _____
(Print the participant's name) (Print physician's name)

(Parent/Guardian's signature) (Date)

CARE PLAN FOR CHILDREN WITH SPECIAL HEALTH NEEDS
-To be completed by a Health Care Provider-

		Today's Date		
Child's Full Name		Date of Birth		
Parent's/Guardian's Name		Telephone No. ()		
Primary Health Care Provider		Telephone No. ()		
Specialty Provider		Telephone No. ()		
Specialty Provider		Telephone No. ()		
Diagnosis(es)				
Allergies				
ROUTINE CARE				
Medication To Be Given at Child Care	Schedule/Dose (When and How Much?)	Route (How?)	Reason Prescribed	Possible Side Effects
List medications given at home:				
NEEDED ACCOMMODATION(S)				
Describe any needed accommodation(s) the child needs in daily activities and why:				
Diet or Feeding: _____				
Classroom Activities: _____				
Naptime/Sleeping: _____				
Toileting: _____				
Outdoor or Field Trips: _____				
Transportation: _____				
Other: _____				
Additional comments: _____				

CARE PLAN FOR CHILDREN WITH SPECIAL HEALTH NEEDS
Continued

SPECIAL EQUIPMENT / MEDICAL SUPPLIES	
1. _____	
2. _____	
3. _____	
EMERGENCY CARE	
CALL PARENTS/GUARDIANS if the following symptoms are present:	

CALL 911 (EMERGENCY MEDICAL SERVICES) if the following symptoms are present, as well as contacting the parents/guardians:	

TAKE THESE MEASURES while waiting for parents or medical help to arrive:	

SUGGESTED SPECIAL TRAINING FOR STAFF	

Health Care Provider Signature	Date

PARENT NOTES (OPTIONAL)	

<i>I hereby give consent for my child's health care provider or specialist to communicate with my child's child care provider or school nurse to discuss any of the information contained in this care plan.</i>	
Parent/Guardian Signature	Date

Important: In order to ensure the health and safety of your child, it is vital that any person involved in the care of your child be aware of your child's special health needs, medication your child is taking, or needs in case of a health care emergency, and the specific actions to take regarding your child's special health needs.

Instructions for Completing the Care Plan for Children with Special Health Needs (CH-15)

This Care Plan template is designed to supplement the Universal Child Health Record (UCHR, CH-14). It should be used for children with special health needs (CSHN). The UCHR is designed to be concise and does not provide sufficient space for detailed instructions that a CSHN might need. Use this Care Plan when your instructions for the child's care cannot be fit on to the UCHR. This Care Plan should be utilized as a template that can be adapted as needed. Not all parts need to be completed for some children, but other children may require extra pages to be attached to fully explain the instructions for the child's care.

In order to facilitate communication between the health care provider and the parent, it may be best to complete this form with the parent/guardian present. Parents often have practical knowledge that is important to incorporate into the plan, such as techniques to get the child to cooperate with treatments and specifics about the child care site/school like the hours attended and the resources/limitations of the out-of-home care provider. There is room at the end for optional parent notes and signature that will give permission for communication between the health care provider and the child care provider or school nurse.

Specific Instructions:

1. Complete the Universal Child Health Record (UCHR, CH-14).
2. Attach a copy of Immunization record.
3. As appropriate check off the box labeled "Special Care Plan Attached."
4. Complete the Care Plan for Children with Special Health Needs
 - Complete the demographic information.
 - The Primary Health Care Provider is the medical home where the child's complete health records are maintained.
 - Specialty providers and their contact information should be included if the specialists play a major role in the child's health care such as adjusting medication doses.
 - Diagnosis – Include major diagnoses (preferably using lay terminology as necessary).
 - Allergies – Include medication allergies and other significant environmental allergies.
 - Routine Care – Complete the medication information. Include important side effects that child care providers should be watching for both with medications administered at home as well as those given at child care.
 - Describe any Needed Accommodations to particular activities.
 - Describe special diets or feeding techniques which may be needed such as feeding pureed foods, maintaining upright positioning during feeds, following a restrictive diet, etc.
 - Classroom activities – List any modifications needed to allow the child to participate such as extra rest breaks, use of adaptive equipment, etc.
 - Outdoor Activities/Field Trips- List any special precautions needed for class trips such as emergency kits, mobile phones, special vehicles, etc.
 - Special Equipment/ Medical Supplies
 - List special equipment that may be needed such as nebulizers, peak flow meters, glucometers, braces, hearing aids, wheelchairs, apnea monitors, etc.
 - Emergency Care
 - Help the child care providers to understand which signs/symptoms merit calling the parents and which are more serious and indicate that EMS should be activated.
 - Describe interim measures that should be taken while waiting for parent or EMS arrival such as administering an asthma nebulizer treatment or an Epi-Pen.
 - Special Staff Training
 - Are there special trainings that staff should attend in order to care for the child such as medication administration training, first aid/CPR, etc.? Include who might be available to provide such training.

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Township of East Brunswick

DIVISION OF RECREATION
AND COMMUNITY SERVICES

Daisy Recreation Program

For Participants: Physician and Parent/Guardian Authorization for Administration of Epinephrine

PLEASE PRINT UNLESS SIGNATURE REQUIRED

Participant's Name _____ Birth Date _____

Previous episode of anaphylaxis: Yes No Asthma? Yes No

MEDICATIONS

ANTI-HISTAMINE: _____ Dose _____

Give antihistamine for the following symptoms: _____

EPINEPHRINE AUTO INJECTOR (0.3mg) (0.15mg)

Give repeat dose in 15 minutes if rescue squad has not arrived (2 auto-injectors will be needed)

Give epinephrine for the following checked symptoms:

- Contact with allergen, but no symptoms
- Skin - hives, itchy rash, extremity swelling
- Lips - itching, tingling, burning, or swelling of lips
- Head /neck - swelling of tongue, mouth, or throat, hoarseness, hacking cough, tightening of throat
- Abdomen - abdominal cramps, nausea, vomiting, diarrhea
- Lungs - repetitive cough, wheezing, shortness of breath
- Heart - thready pulse, low blood pressure, fainting, pale or bluish skin
- Other _____

.....
Please note-in the absence of the Daisy Recreation Program Nurse, a trained delegate (if available) will give epinephrine and any antihistamine order will be disregarded.
.....

SELECT ONE:

- This participant has been trained and is capable of self-administration of the following medication(s):
 - Epinephrine - single dose unit
 - Epinephrine & antihistamine - single dose units

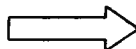
* Under NJ State Law, orders for antihistamine alone cannot be self administered

- This participant is not capable of self-administration of the medications named above.

Physician's Signature _____ Telephone Number _____

Date _____

Physician's Office Stamp
Must be placed here



Participant's Name _____

Emergency Calls: (List Names and Phone Numbers)

1. CALL 911 AND STATE THAT AN ALLERGIC REACTION HAS BEEN TREATED, AND ADDITIONAL EPINEPHRINE MAY BE NEEDED.
2. Mother/Guardian _____ Father/Guardian _____
3. Alternate Contact(s) (1) _____ (2) _____

Parent/Guardian

A current single dose Epinephrine auto-injector must be provided to the Daisy Recreation Program for your child's use (two if a second dose is ordered) All antihistamines and epinephrine must be brought to Daisy Recreation Center by an adult and be provided in the original container, with the prescription label attached. (expired medication will not be accepted)

Select one to sign and date.

1. I verify that my child _____ has a potentially life threatening illness and has been instructed in self-administration of the prescribed medication in a life threatening situation. I hereby give permission for my child to self administer the prescribed medication. I further acknowledge that the Township of East Brunswick shall incur no liability as a result of any injury arising from the self-administration of medication by my child. If procedures specified by New Jersey law and the Township of East Brunswick are followed, I shall indemnify and hold harmless the Township of East Brunswick and it's employees or agents against any claims arising out of self administration of medication by my child.

Signature of Parent/Guardian Date

or

2. I verify that my child _____ has a potentially life threatening illness and is unable to self-administer the prescribed medication in a life threatening situation. I hereby request the Daisy Recreation Program Nurse or delegate (if applicable) administer prescribed medication to my child. I further acknowledge that the Township of East Brunswick shall incur no liability as a result of any injury arising from the administration of medication to my child. If procedures specified by New Jersey law and the Township of East Brunswick are followed, I shall indemnify and hold harmless the Township of East Brunswick and it's employees or agents against any claims arising out of self administration of medication by my child.

Signature of Parent/Guardian Date

<p><u>Please sign</u></p> <p>I give my consent that, a trained delegate may administer epinephrine via a pre-filled auto injector to my child in the absence of the Daisy Recreation Program Nurse. Antihistamines may not be given by a delegate. In the absence of the Daisy Recreation Program Nurse, any antihistamine order will be disregarded and only epinephrine will be administered by a trained delegate.</p> <p>_____ Parent/Guardian Signature Date</p>
--



SEIZURE ACTION PLAN

Effective Date _____

THIS STUDENT IS BEING TREATED FOR A SEIZURE DISORDER. THE INFORMATION BELOW SHOULD ASSIST YOU IF A SEIZURE OCCURS DURING SCHOOL HOURS.

Student's Name: _____ Date of Birth: _____
 Parent/Guardian: _____ Phone: _____ Cell: _____
 Treating Physician: _____ Phone: _____
 Significant medical history: _____

SEIZURE INFORMATION:

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs: _____

Student's reaction to seizure: _____

BASIC FIRST AID: CARE & COMFORT:
(Please describe basic first aid procedures)

Does student need to leave the classroom after a seizure? YES NO
 If YES, describe process for returning student to classroom _____

- Basic Seizure First Aid:**
- ✓ Stay calm & track time
 - ✓ Keep child safe
 - ✓ Do not restrain
 - ✓ Do not put anything in mouth
 - ✓ Stay with child until fully conscious
 - ✓ Record seizure in log
- For tonic-clonic (grand mal) seizure:**
- ✓ Protect head
 - ✓ Keep airway open/watch breathing
 - ✓ Turn child on side

EMERGENCY RESPONSE:

A "seizure emergency" for this student is defined as: _____

Seizure Emergency Protocol: *(Check all that apply and clarify below)*

- Contact school nurse at _____
- Call 911 for transport to _____
- Notify parent or emergency contact _____
- Notify doctor _____
- Administer emergency medications as indicated below _____
- Other _____

- A Seizure is generally considered an Emergency when:
- ✓ A convulsive (tonic-clonic) seizure lasts longer than 5 minutes
 - ✓ Student has repeated seizures without regaining consciousness
 - ✓ Student has a first time seizure
 - ✓ Student is injured or has diabetes
 - ✓ Student has breathing difficulties
 - ✓ Student has a seizure in water

TREATMENT PROTOCOL DURING SCHOOL HOURS: (include daily and emergency medications)

Daily Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Emergency/Rescue Medication _____

Does student have a Vagus Nerve Stimulator (VNS)? YES NO
 If YES, Describe magnet use _____

SPECIAL CONSIDERATIONS & SAFETY PRECAUTIONS: *(regarding school activities, sports, trips, etc.)*

Physician Signature: _____ Date: _____
 Parent Signature: _____ Date: _____

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Asthma Treatment Plan Patient/Parent Instructions



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
- Patient's date of birth
- Patient's doctor's name & phone number
- Parent/Guardian's name & phone number
- 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.

Disclaimers:

The use of this Website/PACNJ Asthma Treatment Plan and its content is at your own risk. The content is provided on an "as is" basis. The American Lung Association of the Mid-Atlantic (ALAM-A), the Pediatric/Adult Asthma Coalition of New Jersey and all affiliates disclaim all warranties, express or implied, statutory or otherwise, including but not limited to the implied warranties or merchantability, non-infringement of third parties' rights, and fitness for a particular purpose.

ALAM-A makes no representations or warranties about the accuracy, reliability, completeness, currency, or timeliness of the content. ALAM-A makes no warranty, representation or guaranty that the information will be uninterrupted or error free or that any defects can be corrected.

In no event shall ALAM-A be liable for any damages (including, without limitation, incidental and consequential damages, personal injury/wrongful death, lost profits, or damages resulting from data or business interruption) resulting from the use or inability to use the content of this Asthma Treatment Plan whether based on warranty, contract, tort or any other legal theory, and whether or not ALAM-A is advised of the possibility of such damages. ALAM-A and its affiliates are not liable for any claim, whatsoever, caused by your use or misuse of the Asthma Treatment Plan, nor of this website.

The Pediatric/Adult Asthma Coalition of New Jersey, sponsored by the American Lung Association of New Jersey, and this publication are supported by a grant from the New Jersey Department of Health and Senior Services (NJDHSS) with funds provided by the U.S. Centers for Disease Control and Prevention (USCDCP) under Cooperative Agreement 5U59EH000206-3. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the NJDHSS or the USCDCP. Although this document has been funded wholly or in part by the United States Environmental Protection Agency under Agreement XA97256707-2 to the American Lung Association of New Jersey, it has not gone through the Agency's publications review process and therefore, may not necessarily reflect the views of the Agency and no official endorsement should be inferred. Information in this publication is not intended to diagnose health problems or take the place of medical advice. For asthma or any medical condition, seek medical advice from your child's or your health care professional.

Asthma Treatment Plan

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

The Pediatric/Adult
Asthma Coalition
of New Jersey

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

Sponsored by
AMERICAN
LUNG
ASSOCIATION.
IN NEW JERSEY



(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
<input type="checkbox"/> Advair® <input type="checkbox"/> 100, <input type="checkbox"/> 250, <input type="checkbox"/> 500	_____ 1 inhalation twice a day
<input type="checkbox"/> Advair® HFA <input type="checkbox"/> 45, <input type="checkbox"/> 115, <input type="checkbox"/> 230	_____ 2 puffs MDI twice a day
<input type="checkbox"/> Alvesco® <input type="checkbox"/> 80, <input type="checkbox"/> 160	_____ <input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs MDI twice a day
<input type="checkbox"/> Asmanex® Twisthaler® <input type="checkbox"/> 110, <input type="checkbox"/> 220	_____ <input type="checkbox"/> 1, <input type="checkbox"/> 2 inhalations <input type="checkbox"/> once or <input type="checkbox"/> twice a day
<input type="checkbox"/> Flovent® <input type="checkbox"/> 44, <input type="checkbox"/> 110, <input type="checkbox"/> 220	_____ 2 puffs MDI twice a day
<input type="checkbox"/> Flovent® Diskus® <input type="checkbox"/> 50 <input type="checkbox"/> 100 <input type="checkbox"/> 250	_____ 1 inhalation twice a day
<input type="checkbox"/> Pulmicort Flexhaler® <input type="checkbox"/> 90, <input type="checkbox"/> 180	_____ <input type="checkbox"/> 1, <input type="checkbox"/> 2 inhalations <input type="checkbox"/> once or <input type="checkbox"/> twice a day
<input type="checkbox"/> Pulmicort Respules® <input type="checkbox"/> 0.25, <input type="checkbox"/> 0.5, <input type="checkbox"/> 1.0	_____ 1 unit nebulized <input type="checkbox"/> once or <input type="checkbox"/> twice a day
<input type="checkbox"/> Qvar® <input type="checkbox"/> 40, <input type="checkbox"/> 80	_____ <input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs MDI twice a day
<input type="checkbox"/> Singulair® <input type="checkbox"/> 4, <input type="checkbox"/> 5, <input type="checkbox"/> 10 mg	_____ 1 tablet daily
<input type="checkbox"/> Symbicort® <input type="checkbox"/> 80, <input type="checkbox"/> 160	_____ <input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs MDI twice a day
<input type="checkbox"/> Other	
<input type="checkbox"/> 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: _____

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

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
<input type="checkbox"/> Accuneb® <input type="checkbox"/> 0.63, <input type="checkbox"/> 1.25 mg	_____ 1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Albuterol <input type="checkbox"/> 1.25, <input type="checkbox"/> 2.5 mg	_____ 1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Albuterol <input type="checkbox"/> Pro-Air <input type="checkbox"/> Proventil®	_____ 2 puffs MDI every 4 hours as needed
<input type="checkbox"/> Ventolin® <input type="checkbox"/> Maxair <input type="checkbox"/> Xopenex®	_____ 2 puffs MDI every 4 hours as needed
<input type="checkbox"/> Xopenex® <input type="checkbox"/> 0.31, <input type="checkbox"/> 0.63, <input type="checkbox"/> 1.25 mg	_____ 1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Increase the dose of, or add:	
<input type="checkbox"/> 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!

<input type="checkbox"/> Accuneb® <input type="checkbox"/> 0.63, <input type="checkbox"/> 1.25 mg	_____ 1 unit nebulized every 20 minutes
<input type="checkbox"/> Albuterol <input type="checkbox"/> 1.25, <input type="checkbox"/> 2.5 mg	_____ 1 unit nebulized every 20 minutes
<input type="checkbox"/> Albuterol <input type="checkbox"/> Pro-Air <input type="checkbox"/> Proventil®	_____ 2 puffs MDI every 20 minutes
<input type="checkbox"/> Ventolin® <input type="checkbox"/> Maxair <input type="checkbox"/> Xopenex®	_____ 2 puffs MDI every 20 minutes
<input type="checkbox"/> Xopenex® <input type="checkbox"/> 0.31, <input type="checkbox"/> 0.63, <input type="checkbox"/> 1.25 mg	_____ 1 unit nebulized every 20 minutes
<input type="checkbox"/> Other	

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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.
- 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