

ASTHMA HEALTH CARE ACTION PLAN & AUTHORIZATION FOR MEDICATION

TO BE COMPLETED BY PARENT:

SCHOOL DIVISION NAME: _____

Child's Name _____ Date of Birth _____ School _____ Grade _____

Parent/Caregiver _____ Phone (H) _____ Phone (W) _____ Phone (Cell) _____

Address _____ City _____ Zip _____

Emergency Contact _____ Relationship _____ Phone _____

Name of Provider (Physician/Nurse Practitioner/Physician's Assistant) _____ Office Phone (____) _____
Office Fax (____) _____

What triggers your child's asthma attack? (Check all that apply)

- Illness Cigarette or other smoke Food _____
 Emotions Exercise/physical activity Allergies: Cat Dog Dust Mold Pollen
 Weather changes Chemical odors Other: _____

Describe the symptoms your child experiences before or during an asthma episode: (Check all that apply)

- Cough Tightness in chest Rubbing chin/neck
 Shortness of breath Breathing hard/fast Feeling tired/weak
 Wheezing Runny nose Other _____

TO BE COMPLETED BY HEALTH CARE PROVIDER:

The child's asthma is: Intermittent Mild Persistent Moderate Persistent Severe Persistent Exercise-induced

SYMPTOMS &/OR Monitoring		Treatment		
WELL • Usual medications control asthma • No cough or wheeze • Able to sleep through the night • No rescue meds needed • No activity restrictions (PE & recess are okay)	GREEN ZONE Personal Best = _____ to _____	Medication Relievers/Rescue <input type="checkbox"/> Albuterol (with spacer) or nebulizer <input type="checkbox"/> Other _____ Controllers <input type="checkbox"/> Inhaled Corticosteroid _____ <input type="checkbox"/> Advair <input type="checkbox"/> Symbicort <input type="checkbox"/> Other _____ Leukotriene Modifier: <input type="checkbox"/> Singulair <input type="checkbox"/> Other _____ Other _____	How Much 2 puffs 1 min. apart (or 1 nebulizer treatment) every 4-6 hrs. as needed	When <input type="checkbox"/> 2 puffs or 1 nebulizer treatment 5-15 min. before physical activity
	SICK • Needs reliever medications more often • Increased asthma symptoms (shortness of breath, cough, chest pain) • Wakes at night due to asthma • Unable to do usual activities	YELLOW ZONE to _____	1. <input type="checkbox"/> Continue daily controller medications 2. <input type="checkbox"/> Give albuterol 2-6 puffs (1 min between puffs) with spacer or 1 nebulizer treatment, wait 20 min 3. <input type="checkbox"/> If no improvement, repeat 2-6 puffs or 1 nebulizer treatment, wait 20 mins. Call Parent and/or Provider. <p style="text-align: center;"><u>If no improvement, CALL 911</u></p> <p style="text-align: center;"><u>If child returns to Green Zone:</u></p> <input type="checkbox"/> Continue to give albuterol 2 puffs every 4 hours for 1 to 2 more days <input type="checkbox"/> No physical activity <input type="checkbox"/> Physical activity as tolerated i.e. PE & recess at school	
EMERGENCY • Reliever medications do not help • Very short of breath • Constant cough	RED ZONE < _____	<input type="checkbox"/> Give albuterol 2-6 puffs (with spacer) or 1 nebulizer treatment NOW! May repeat once after 20 min. <p style="text-align: center;"><u>If there is no improvement, call parent and/or 911.</u></p> <u>Call 911 immediately if:</u> <ul style="list-style-type: none"> • Child is struggling to breathe and there is no improvement in 20 minutes after taking albuterol • Child has trouble talking or walking • Child has lips or fingernails that are gray or blue • Child's chest or neck is pulling in with breathing 		

PATIENT/STUDENT INSTRUCTIONS:

- Student has been instructed in the proper use of all his/her asthma medications, and in my opinion, the student can carry and use his/her inhaler at school
 Student is to notify his/her designated school health officials after using inhaler per school protocol
 Student needs supervision or assistance to use his/her inhaler Student should **NOT** carry his/her inhaler while at school

HEALTH CARE PROVIDER SIGNATURE _____ PLEASE PRINT PROVIDER'S NAME _____ DATE _____ Valid for current school year

I give permission for school personnel to follow this plan, administer medication and care for my child and contact my provider if necessary. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I approve this Asthma Management Plan for my child.

PARENT SIGNATURE _____

DATE _____

EMAIL _____

CINCH _____

Virginia Asthma Coalition
revision: May, 2010

Cc: principal _____ office staff _____ librarian _____ cafeteria mgr. _____ bus driver/transportation _____ Coach/PE _____ teachers _____