

ASTHMA HEALTH CARE ACTION PLAN & AUTHORIZATION FOR MEDICATION

TO BE COMPLETED BY PARENT:

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 Physician/Nurse Practitioner/Physician 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	Peak Flow 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 _____	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 33%;">Medication</th> <th style="width: 33%;">How Much</th> <th style="width: 34%;">When</th> </tr> </thead> <tbody> <tr> <td colspan="3">Relievers/Rescue</td> </tr> <tr> <td><input type="checkbox"/> Albuterol (with spacer) or nebulizer</td> <td>2 puffs 1 min. apart (or 1 nebulizer treatment) every 4-6 hrs. as needed</td> <td><input type="checkbox"/> 2 puffs or 1 nebulizer treatment 5-15 min. before physical activity</td> </tr> <tr> <td colspan="3">Other _____</td> </tr> <tr> <td colspan="3">Controllers</td> </tr> <tr> <td><input type="checkbox"/> Inhaled Corticosteroid _____</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Advair</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Symbicort</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Other _____</td> <td></td> <td></td> </tr> <tr> <td colspan="3">Leukotriene Modifier:</td> </tr> <tr> <td><input type="checkbox"/> Singulair</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Other _____</td> <td></td> <td></td> </tr> <tr> <td colspan="3">Other _____</td> </tr> </tbody> </table>	Medication	How Much	When	Relievers/Rescue			<input type="checkbox"/> Albuterol (with spacer) or nebulizer	2 puffs 1 min. apart (or 1 nebulizer treatment) every 4-6 hrs. as needed	<input type="checkbox"/> 2 puffs or 1 nebulizer treatment 5-15 min. before physical activity	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 _____		
Medication	How Much	When																																							
Relievers/Rescue																																									
<input type="checkbox"/> Albuterol (with spacer) or nebulizer	2 puffs 1 min. apart (or 1 nebulizer treatment) every 4-6 hrs. as needed	<input type="checkbox"/> 2 puffs or 1 nebulizer treatment 5-15 min. before physical activity																																							
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 _____																																									
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 MD <p style="text-align: center;"><u>If no improvement, CALL 911</u></p> <p>If child returns to Green Zone:</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> <p>Call 911 immediately if:</p> <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

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

I give permission for school personnel to follow this plan, administer medication and care for my child and contact my physician 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

CINCH
Virginia Asthma Coalition
 revision: January, 2008

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