ASTHMA ACTION PLAN & AUTHORIZATION FOR MEDICATION

Attachment I
Regulation 757-5

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** _____	**Controllers & Relievers**	**How much**	**When**
		☐ Inhaled Corticosteroid _____		
		☐ Advair		
		☐-Symbicort		
		☐ Other _____		
		Leukotriene Modifier: Singulair		
		☐ Other _____		
		Relievers		
		☐ Albuterol (with spacer) or nebulizer	2 puffs 1 min. apart (or 1 nebulizer treatment) every 4-6 hrs. as needed	☐ **2 puffs or 1 nebulizer treatment 5 min. before physical activity**
		☐ 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. ☐ Continue daily controller medications 2. ☐ Give albuterol 2-6 puffs (1 min. between puffs) with spacer or 1 nebulizer treatment, wait 20 min. 3. ☐ If no improvement, repeat 2-6 puffs or 1 nebulizer treatment, wait 20 min. **Call parent and/or MD.** **<u>If no improvement, CALL 911</u>** **If child returns to Green Zone:** ☐ Continue to give albuterol 2 puffs every 4 hours for 1 to 2 more days ☐ No physical exercise ☐ Physical exercise as tolerated i.e. PE & recess at school		
EMERGENCY! • Reliever medications do not help • Very short of breath • Constant cough	**RED ZONE** <_____	☐ **Give albuterol (2-6 puffs (with spacer) or 1 nebulizer treatment NOW! May repeat once after 20 min.** **<u>If there is no improvement, call parent and/or 911.</u>** **<u>Call 911 immediately if:</u>** • Child is struggling to breathe and there is no improvement 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 <u>can carry and use his/her inhaler at school</u>
☐ 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 shall **<u>NOT</u>** be able to 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**

cc: principal____ office staff____ librarian____ cafeteria mgr.____ bus driver/transportation____ Coach/PE____ teachers____

CINCH
Virginia Asthma Coalition
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