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
- ☐ Emotions
- ☐ Weather changes
- ☐ Cigarette or other smoke
- ☐ Exercise/physical activity
- ☐ Chemical odors

Food ______________________________

Allergies: ☐ Cat ☐ Dog ☐ Dust ☐ Mold ☐ Pollen

Other: ______________________________

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

- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Tightness in chest
- ☐ Breathing hard/fast
- ☐ Runny nose
- ☐ Rubbing chin/neck
- ☐ Feeling tired/weak
- ☐ 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 ______	See medication table below
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 mins. **Call parent and/or MD** **If no improvement , CALL 911** **If child returns to Green Zone:** ☐ Continue to give albuterol 2 puffs every 4 hours for 1 to 2 more days ☐ No physical activity ☐ Physical activity 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.** **If there is no improvement, call parent and/or 911.** **Call 911 immediately if:** • 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

Green Zone Treatment:

Medication	How Much	When
Relievers/Rescue		
☐ 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 5-15 min. before physical activity**
☐ **Other** ______________		
Controllers		
☐ Inhaled Corticosteroid _____		
☐ Advair		
☐ Symbicort		
☐ Other		
Leukotriene Modifier:		
☐ Singulair		
☐ Other ______________		
Other ______________		

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**

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

CINCH
Virginia Asthma Coalition
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