

ASTHMA MANAGEMENT PLAN & AUTHORIZATION FOR MEDICATION

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN:

Student Name: _____ Birth Date: _____ School: _____ Grade: _____
 Parent/Guardian: _____ Phone (H): _____ Phone (W): _____
 Phone (Cell): _____ E-mail: _____
 Parent/Guardian: _____ Phone (H): _____ Phone (W): _____
 Phone (Cell): _____ E-mail: _____
 Emergency Contact: _____ Relationship: _____ Phone: _____
 Asthma Care Provider: _____ Office Phone: _____ Fax: _____
 Hospital Preference: _____

TO BE COMPLETED BY ASTHMA CARE PROVIDER:

RESCUE (quick relief) MEDICATION:

MONITORING

TREATMENT

RED	<p>RED ZONE: EMERGENCY SIGNS</p> <ul style="list-style-type: none"> Lips and fingernails are blue or gray Trouble walking and talking due to shortness of breath Loss of consciousness <p>RED ZONE: DANGER SIGNS</p> <ul style="list-style-type: none"> Very short breath, or Rescue medications have not helped, or Cannot do usual activities, or Symptoms are same or get worse after 24 hours in Yellow Zone 	<ul style="list-style-type: none"> Give rescue medication: <input type="checkbox"/> 2 <input type="checkbox"/> 4 <input type="checkbox"/> 6 puffs (1 min. between puffs) or 1 nebulizer treatment Call parent and/or Asthma Care Provider Call 911 NOW if: <ol style="list-style-type: none"> Unable to reach medical care provider after arriving in the red zone Child is struggling to breathe and there is no improvement after taking albuterol May repeat rescue medication every 10 minutes if symptoms do not improve, until medical assistance has arrived or you are at the emergency department 																				
YELLOW	<p>YELLOW ZONE: CAUTION</p> <ul style="list-style-type: none"> Cough, wheeze, chest tightness, or shortness of breath, or Waking at night due to asthma, or Can do some, but not all, usual activities 	<ul style="list-style-type: none"> Continue daily controller medications Give rescue medication: <input type="checkbox"/> 2 <input type="checkbox"/> 4 <input type="checkbox"/> 6 puffs (1 min. between puffs) OR 1 nebulizer treatment every 4 hours as needed Wait 10 minutes and recheck symptoms If not better, go to RED ZONE If symptoms improve, may return to class or normal activity, or _____ <p>_____</p> <ul style="list-style-type: none"> Parent/School RN: If needed, coordinate rescue medications to be given every 4 hours for <input type="checkbox"/> 2 <input type="checkbox"/> 3 days, if symptoms remain improved If symptoms are not gone after <input type="checkbox"/> 2 <input type="checkbox"/> 3 days, move to RED ZONE 																				
GREEN	<p>GREEN ZONE: WELL</p> <ul style="list-style-type: none"> No cough, wheeze, chest tightness, or shortness of breath during the day or night Can do usual activities 	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">MEDICATION</th> <th style="text-align: left;">HOW MUCH</th> <th style="text-align: left;">WHEN</th> </tr> </thead> <tbody> <tr> <td style="height: 40px;"></td> <td></td> <td>Before Exercise <input type="checkbox"/> Recess <input type="checkbox"/> PE/Sports <i>(not to exceed every 4 hours)</i></td> </tr> </tbody> </table>	MEDICATION	HOW MUCH	WHEN			Before Exercise <input type="checkbox"/> Recess <input type="checkbox"/> PE/Sports <i>(not to exceed every 4 hours)</i>	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">DAILY CONTROLLER MEDICATION</th> <th style="text-align: left;">HOW MUCH</th> <th style="text-align: left;">WHEN</th> </tr> </thead> <tbody> <tr> <td style="height: 20px;"></td> <td></td> <td></td> </tr> <tr> <td style="height: 20px;"></td> <td></td> <td></td> </tr> <tr> <td style="height: 20px;"></td> <td></td> <td></td> </tr> </tbody> </table>	DAILY CONTROLLER MEDICATION	HOW MUCH	WHEN										
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- Administer medications as instructed above
- 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 needs supervision or assistance to use his/her inhaler medication
- Student should NOT carry his/her inhaler while at school Have student use spacer with inhaler medication

ASTHMA CARE PROVIDER SIGNATURE _____ NAME PRINTED _____ DATE _____

I give permission for the school nurse and any pertinent staff caring for my child to follow this plan, administer medication and care for my child, contact my asthma care provider if necessary and for this form to be faxed / emailed to my child's school or be shared with school staff per FERPA guidelines. I assume full responsibility for providing the school with prescribed medication and delivery / monitoring devices.

PARENT SIGNATURE _____ DATE _____