

## 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)**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Illness         | <input type="checkbox"/> Cigarette or other smoke   | Food _____   |
| <input type="checkbox"/> Emotions        | <input type="checkbox"/> Exercise/physical activity | Allergies: <input type="checkbox"/> Cat <input type="checkbox"/> Dog <input type="checkbox"/> Dust <input type="checkbox"/> Mold <input type="checkbox"/> Pollen |
| <input type="checkbox"/> Weather changes | <input type="checkbox"/> Chemical odors             | Other: _____   |

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

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Cough               | <input type="checkbox"/> Tightness in chest  | <input type="checkbox"/> Rubbing chin/neck  |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Breathing hard/fast | <input type="checkbox"/> Feeling tired/weak |
| <input type="checkbox"/> Wheezing            | <input type="checkbox"/> Runny nose          | <input type="checkbox"/> 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																																							
<b>WELL</b> • 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)	<b>GREEN ZONE</b>  Personal Best = _____  to _____	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">Medication</th> <th style="width: 30%;">How Much</th> <th style="width: 40%;">When</th> </tr> </thead> <tbody> <tr> <td colspan="3"><b>Relievers/Rescue</b></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"><input type="checkbox"/> Other _____</td> </tr> <tr> <td colspan="3"><b>Controllers</b></td> </tr> <tr> <td colspan="3"><input type="checkbox"/> Inhaled Corticosteroid _____</td> </tr> <tr> <td colspan="3"><input type="checkbox"/> Advair _____</td> </tr> <tr> <td colspan="3"><input type="checkbox"/> Symbicort _____</td> </tr> <tr> <td colspan="3"><input type="checkbox"/> Other _____</td> </tr> <tr> <td colspan="3"><b>Leukotriene Modifier:</b></td> </tr> <tr> <td colspan="3"><input type="checkbox"/> Singulair _____</td> </tr> <tr> <td colspan="3"><input type="checkbox"/> Other _____</td> </tr> <tr> <td colspan="3"><b>Other</b> _____</td> </tr> </tbody> </table>	Medication	How Much	When	<b>Relievers/Rescue</b>			<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	<input type="checkbox"/> Other _____			<b>Controllers</b>			<input type="checkbox"/> Inhaled Corticosteroid _____			<input type="checkbox"/> Advair _____			<input type="checkbox"/> Symbicort _____			<input type="checkbox"/> Other _____			<b>Leukotriene Modifier:</b>			<input type="checkbox"/> Singulair _____			<input type="checkbox"/> Other _____			<b>Other</b> _____		
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<b>SICK</b> • 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	<b>YELLOW ZONE</b>  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. <b>Call parent and/or MD</b>  <p style="text-align: center;"><b><u>If no improvement, CALL 911</u></b></p> <p><b>If child returns to Green Zone:</b></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 <input type="checkbox"/> Give albuterol 2-6 puffs (with spacer) or 1 nebulizer treatment NOW! May repeat once after 20 min.																																							
<b>EMERGENCY</b> • Reliever medications do not help • Very short of breath • Constant cough	<b>RED ZONE</b>  < _____	<p style="text-align: center;"><b><u>If there is no improvement, call parent and/or 911.</u></b></p> <p><b>Call 911 immediately if:</b></p> <ul style="list-style-type: none"> <li>• Child is struggling to breathe and there is no improvement in 20 minutes after taking albuterol</li> <li>• Child has trouble talking or walking</li> <li>• Child has lips or fingernails that are gray or blue</li> <li>• Child's chest or neck is pulling in with breathing</li> </ul>																																							

**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 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 \_\_\_\_\_