# 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 | How much | When |
|---|---|---|---|---|
| **WELL** | **GREEN ZONE** | **Controllers & Relievers** | | |
| • Usual medications control asthma | | □ Inhaled Corticosteroid ________ | | |
| • No cough or wheeze | | □ Advair | | |
| • Able to sleep through the night | **Personal Best =** | □-Symbicort | | |
| • No rescue meds needed | | □ Other | | |
| • No activity restrictions (PE & recess are okay) | _______ | **Leukotriene Modifier:** Singulair | | |
| | | □ Other ______________ | | |
| | | **Relievers** | | |
| | _______ to _______ | □ 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**<br>• Needs reliever medications more often<br>• Increased asthma symptoms (shortness of breath, cough, chest pain)<br>• Wakes at night due to asthma<br>• Unable to do usual activities | **YELLOW ZONE**<br>_____ to _____ | 1. □ Continue daily controller medications<br>2. □ Give albuterol 2-6 puffs (1 min. between puffs) with spacer or 1 nebulizer treatment, wait 20 min.<br>3. □ If no improvement, repeat 2-6 puffs or 1 nebulizer treatment, wait 20 min. **Call parent and/or MD.**<br>**<u>If no improvement, CALL 911</u>**<br>**If child returns to Green Zone:**<br>□ Continue to give albuterol 2 puffs every 4 hours for 1 to 2 more days<br>□ No physical exercise □ Physical exercise as tolerated i.e. PE & recess at school | | |
| **EMERGENCY!**<br>• Reliever medications do not help<br>• Very short of breath<br>• Constant cough | **RED ZONE**<br><________ | □**Give albuterol (2-6 puffs (with spacer) or 1 nebulizer treatment NOW! May repeat once after 20 min.**<br>**<u>If there is no improvement, call parent and/or 911.</u>**<br>**<u>Call 911 immediately if:</u>**<br>• Child is struggling to breathe and there is no improvement 20 minutes after taking albuterol<br>• Child has trouble talking or walking<br>• Child has lips or fingernails that are gray or blue<br>• 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**

**CINCH**
**Virginia Asthma Coalition**
revision 3/07

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