

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: <input type="checkbox"/> Intermittent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent <input type="checkbox"/> 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 _____	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%;">Controllers & Relievers</th> <th style="width: 25%;">How Much</th> <th style="width: 25%;">When</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Inhaled Corticosteroid _____</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Advair</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Symbicort</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Other _____</td> <td></td> <td></td> </tr> <tr> <td colspan="3">Leukotriene Modifier:</td> </tr> <tr> <td><input type="checkbox"/> Singulair</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Other _____</td> <td></td> <td></td> </tr> <tr> <td colspan="3">Relievers</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 min. before physical activity</td> </tr> <tr> <td><input type="checkbox"/> Other _____</td> <td></td> <td></td> </tr> <tr> <td colspan="3">Other</td> </tr> </tbody> </table>	Controllers & Relievers	How Much	When	<input type="checkbox"/> Inhaled Corticosteroid _____			<input type="checkbox"/> Advair			<input type="checkbox"/> Symbicort			<input type="checkbox"/> Other _____			Leukotriene Modifier:			<input type="checkbox"/> Singulair			<input type="checkbox"/> Other _____			Relievers			<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 min. before physical activity	<input type="checkbox"/> Other _____			Other				
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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. <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. Call parent and/or MD <p style="text-align: center;"><u>If no improvement, CALL 911</u></p> <p style="text-align: center;"><u>If child returns to Green Zone:</u></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																																						
EMERGENCY • Reliever medications do not help • Very short of breath • Constant cough	RED ZONE < _____	<input type="checkbox"/> Give albuterol 2-6 puffs (with spacer) or 1 nebulizer treatment NOW! May repeat once after 20 min. <p style="text-align: center;"><u>If there is no improvement, call parent and/or 911.</u></p> <p><u>Call 911 immediately if:</u></p> <ul style="list-style-type: none"> • 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 																																						
PATIENT/STUDENT INSTRUCTIONS: <input type="checkbox"/> 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 <input type="checkbox"/> Student is to notify his/her designated school health officials after using inhaler per school protocol <input type="checkbox"/> Student needs supervision or assistance to use his/her inhaler <input type="checkbox"/> Student shall NOT be able to carry his/her inhaler while at school																																								
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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 revision 3/07	