

ASTHMA MANAGEMENT PLAN & AUTHORIZATION FOR MEDICATION

TO BE COMPLETED BY PARENT:

Patient's Name _____ Date of Birth _____ School _____ Grade _____
 School E-mail _____ School Fax () _____
 Parent/Caregiver _____ Phone (H) _____ Phone (W) _____
 Phone (Cell) _____ E-mail _____
 Emergency Contact _____ Relationship _____ Phone _____
 Asthma Care Provider _____ Office Phone () _____
 Office E-mail _____ Office Fax () _____ (please mark best contact)

TO BE COMPLETED BY ASTHMA CARE PROVIDER

RESCUE (quick-relief) MEDICATION: _____

	MONITORING	TREATMENT																	
RED	<p>RED ZONE: DANGER SIGNS</p> <ul style="list-style-type: none"> • Very short of breath, or • Rescue medicines have not helped, or • Cannot do usual activities, or • Symptoms are same or get worse after 24 hours in Yellow Zone <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 	<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"> 1. Unable to reach medical care provider after arriving in the red zone 2. Child is struggling to breathe and there is no improvement after taking albuterol 3. 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>• Parent/School Nurse: 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</p> <ul style="list-style-type: none"> • If symptoms are not gone after <input type="checkbox"/> 2 <input type="checkbox"/> 3 days, move to the 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="width: 35%;">MEDICATION</th> <th style="width: 25%;">HOW MUCH</th> <th style="width: 35%;">WHEN</th> </tr> </thead> <tbody> <tr> <td></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> <tr> <th>DAILY CONTROLLER MEDICATION</th> <th>HOW MUCH</th> <th>WHEN</th> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </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>	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 _____ PLEASE PRINT PROVIDER NAME _____ 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 _____