WILMINGTON C.A.R.E.S.
ASTHMA CARE PLAN 2018-19

Student's Name: _____ Grade: ____ School: _____

Daily Medications, Dose & Times Given: _____

Medication Side Effects: _____

Peak Flow Meter: Yes ____ No ____ Spacer: Yes ____ No ____

Triggers: (check those that apply)
___Colds & Viruses ___Weather ___Stress ___Other: _____

Instructions for Staff:

- Observe child for symptoms of respiratory difficulty
  - ✓ Wheezing
  - ✓ Cough
  - ✓ Shortness of Breath
- Have child stop what he is doing.
- Assist child with Inhaler: _____
  *Child has permission to self-administer: Yes ___ No ___ (see MD order)
- CARES Staff who administers/assists child with inhaler will contact parent with time of admin.
- Call/notify CARES Nurse: Melinda Danizio, cell: 978-815-1510 whenever medication is administered. If CARES nurse is unavailable, contact CARES Consultant Nurse: Doreen Crowe, cell: 978-423-5315.
- **IF CHILD DOES NOT RESPOND TO MEDICATION UPON INITIAL EPISODE, CALL MOM OR DAD THEN CALL 911 IF HE IS IN DISTRESS OR FOR ANY OF THE FOLLOWING:**
  - ❖ **TURNING BLUE**
  - ❖ **RAPID, LABORED BREATHING**
  - ❖ **DIFFICULTY CARRYING ON A CONVERSATION DUE TO DIFFICULTY BREATHING**
  - ❖ **SHALLOW, RAPID BREATHING**
  - ❖ **BLUENESS OF FINGERNAILS & LIPS**
  - ❖ **DECREASED LEVEL OF CONSCIOUSNESS**

Mother: _____ Cell Phone: _____

Father: _____ Cell Phone: _____

Alt. Contact:_____ Cell Phone: _____

_____ _____
Parent/Guardian Signature Date

_____ _____
CARES Nurse Date

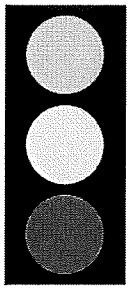
_____
For CARES Nurse:
Person(s) trained to administer medication listed above in the absence of the CARES Nurse:

_____ _____ _____ _____
Staff Member Date Staff Member Date

# Massachusetts Asthma Action Plan

| Name: | | Date: |
|---|---|---|
| Birth Date: | Doctor/Nurse Name: | Doctor/Nurse Phone #: |
| Patient Goal: | Parent/Guardian Name & Phone: | |
| Important! Avoid things that make your asthma worse: | | |

**Personal Best Peak Flow:** _____



The colors of a traffic light will help you use your asthma medicine.

**Green** means **Go Zone!**
Use controller medicine.

**Yellow** means **Caution Zone!**
Add quick-relief medicine.

**Red** means **Danger Zone!**
Get help from a doctor.

## GO – You're Doing Well! ➡ Use these daily controller medicines:

**You have *all* of these:**
- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can go to school and play



Peak flow from _____ to _____

| MEDICINE/ROUTE | HOW MUCH | HOW OFTEN/WHEN |
|---|---|---|
| | | |
| | | |
| | | |

## CAUTION – Slow Down! ➡ Continue with green zone medicine and add:

**You have *any* of these:**
- First signs of a cold
- Cough
- Mild wheeze
- Tight Chest
- Coughing, wheezing, or trouble breathing at night



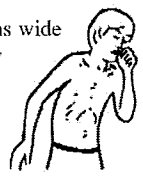
Peak flow from _____ to _____

| MEDICINE/ROUTE | HOW MUCH | HOW OFTEN/WHEN |
|---|---|---|
| | | |
| | | |
| | | |

CALL YOUR DOCTOR/NURSE: _____

## DANGER – Get Help! ➡ Take these medicines and call your doctor now.

**Your asthma is getting worse fast:**
- Medicine is not helping
- Breathing is hard and fast
- Nose opens wide
- Ribs show
- Can't talk well



Peak flow from _____ to _____

| MEDICINE/ROUTE | HOW MUCH | HOW OFTEN/WHEN |
|---|---|---|
| | | |
| | | |
| | | |

**GET HELP FROM A DOCTOR NOW! Do not be afraid of causing a fuss. Your doctor will want to see you right away. It's important! If you cannot contact your doctor, go directly to the emergency room and bring this form with you. DO NOT WAIT.**

Make an appointment with your doctor/nurse within two days of an ER visit or hospitalization.

Doctor/NP/PA Signature: _____ Date: _____

I give permission to the school nurse, my child's doctor/NP/PA or _____ to share information about my child's asthma.

Parent/Guardian Signature: _____ Date: _____

****SEE BACK OF SCHOOL COPY FOR STUDENT MEDICATION ADMINISTRATION AUTHORIZATION****

ADAPTED FROM NIH PUBLICATION (7/20/01)

*Make copies of this plan for: patient/parent, provider, and school.*

## **IMPORTANT INSTRUCTIONS: SEPARATE THIS PAGE BEFORE WRITING**

### Consent for administration of medication in school:

I consent to have the school nurse or school personnel designated by the school nurse administer the medication as prescribed on the reverse side of page.

Parent/Guardian Signature _____ DATE_____

### Authorization for student self-administration of medication in school:

I have instructed this student in the proper way to use his/her medications. Medications administered must be consistent with school policy and a medication plan must be developed with the school nurse in accordance with the Massachusetts Regulations Governing the Administration of Prescription Medications in Public and Private Schools (105 CMR 210.000), as printed below. Translated copies of the regulation can be obtained from the Massachusetts Department of Public Health, 250 Washington Street, Boston, MA 02118. It is my professional opinion that this student may self-administer the medication and may be allowed to carry and use his/her medications by him/herself.

**COMMENTS/SPECIAL INSTRUCTIONS:**

| **SIGNATURES** | | **DATE** |
|---|---|---|
| **Student's Doctor/Nurse** | _____ | _____ |
| **Parent/Guardian** | _____ | _____ |
| **Medication administration plan completed** | _____ | _____ |
| **School Nurse's approval** | _____ | _____ |
| | **SIGNATURE** | |

Listed below are regulations governing the self-administration of prescription medication 105 CMR 210.006

(A) Consistent with school policy, students may self-administer prescription medication provided that certain conditions are met. For the purposes of 105 CMR 2100.000, "self-administration" shall mean that the student is able to consume or apply prescription medication in the manner directed by the licensed prescriber, without additional assistance or direction.

(B) The school nurse may permit self-medication of prescription medication by a student provided that the following requirements are met:

(1) the student, school nurse and parent/guardian, where appropriate, enter into an agreement which specifies the conditions under which prescription medication may be self-administered;

(2) the school nurse, as appropriate, develops a medication administration plan (105 CMR 210.005 (E)) which contains only those elements necessary to ensure safe self-administration of prescription medication;

(3) the school nurse evaluates the student's health status and abilities and deems self-administration safe and appropriate. As necessary, the school nurse shall observe initial self-administration of prescription medication;

(4) the school nurse is reasonably assured that the student is able to identify the appropriate prescription medication, knows the frequency and time of day for which the prescription medication is ordered, and follows the school self-administration protocols;

(5) there is written authorization from the student's parent or guardian that the student may self-medicate, unless the student has consented to treatment under M.G.L. c. 112,§ 12F or other authority permitting the student to consent to medical treatment without parental permission;

(6) if requested by the school nurse, the licensed prescriber provides a written order for self-administration;

(7) the student follows a procedure for documentation of self-administration of prescription medication;

(8) the school nurse establishes a policy for the safe storage of self-administered prescription medication and, as necessary, consults with teachers, the student and parent/guardian, if appropriate, to determine a safe place for storing the prescription medication for the individual student, while providing for accessibility if the student's health needs require it. This information shall be included in the medication administration plan. In the case of an inhaler or other preventive or emergency medication, whenever possible, a backup supply of the prescription medication shall be kept in the health room or a second readily available location;

(9) the school nurse develops and implements a plan to monitor the student's self-administration, based on the student's abilities and health status. Monitoring may include teaching the student the correct way of taking the prescription medication, reminding the student to take the prescription medication, visual observation to ensure compliance, recording that the prescription medication was taken, and notifying the parent, guardian or licensed prescriber of any side effects, variation from the plan, or the student's refusal or failure to take the prescription medication;

(10) with parental/guardian and student permission, as appropriate, the school nurse may inform appropriate teachers and administrators that the student is self-administering a prescription medication.