

ASTHMA MANAGEMENT PLAN & AUTHORIZATION FOR MEDICATION

TO BE COMPLETED BY PARENT

Patient's Name _____ Date of Birth _____ School _____
Grade _____ School Phone _____ School Fax (____) _____
Parent/Caregiver _____ Relationship _____ Email _____
Phone (Cell) _____ Phone (H) _____ Phone (W) _____
Emergency Contact _____ Relationship _____ Phone _____
Asthma Care Provider _____ Office Phone (____) _____ Office Fax (____) _____

**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 zone2. Child is struggling to breath and there is no improvement after taking albuterol3. 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	MEDICATION	HOW MUCH	WHEN
				Before exercise <input type="checkbox"/> Recess <input type="checkbox"/> PE/Sports (not to exceed every 4 hours)
		DAILY CONTROLLER MEDICATION	HOW MUCH	WHEN

- 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
- Allowed to swim One on one supervision only Shallow end only
- PE/Other activity restriction: _____

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 _____