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 **RED ZONE: DANGER SIGNS** • 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 **RED ZONE: EMERGENCY SIGNS** • Lips and fingernails are blue or gray • Trouble walking and talking due to Shortness of breath • Loss of consciousness	• Give rescue medication ❒ 2 ❒ 4 ❒ 6 puffs (1 min between puffs) or 1 nebulizer treatment • **Call parent and/or Asthma Care Provider** • **Call 911 NOW if:** 1. Unable to reach medical care provider after arriving in the red zone 2. Child is struggling to breath 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 **YELLOW ZONE: CAUTION** • Cough, wheeze, chest tightness, or shortness of breath, or • Waking at night due to asthma, or • Can do some, but not all, usual activities	• Continue daily controller medications • Give rescue medication: ❒ 2 ❒ 4 ❒ 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** _____ • **Parent/School Nurse:** If needed, coordinate rescue medications to be given every 4 hours for ❒ 2 ❒ 3 days, if symptoms remain improved • If symptoms are not gone after ❒ 2 ❒ 3 days, move to the **RED ZONE**
GREEN **GREEN ZONE: WELL** • No cough, wheeze, chest tightness, or shortness of breath during the day or night • Can do usual activities	

MEDICATION	HOW MUCH	WHEN
		Before exercise ❒ Recess ❒ 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