ASTHMA MANAGEMENT PLAN & AUTHORIZATION FOR MEDICATION

TO BE COMPLETED BY PARENT: Deta of Pinth School Crade				
Patient's Name Date of Birth School Grade \$\times \text{School E-mail} \tag{Grade} Grad				
D 50	chool E-mail	D School Fax ()	(TAT)
Parent/Caregiver Phone (H) Phone (W)				
Phone (Cell)E-mail Emergency Contact Relationship Phone				
Eme	ergency Contact		Phone	
Asthma Care Provider				
	ffice E-mail			(please mark best contact)
TO BE COMPLETED BY ASTHMA CARE PROVIDER RESCUE (quick-relief) MEDICATION:				
M	ONITORING	TREATMENT		
RED	 RED ZONE: EMERGENCY SIGNS Lips and fingernails are blue or gray Trouble walking and talking due to shortness of breath Loss of consciousness 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 	 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: Unable to reach medical care provider after arriving in the red zone Child is struggling to breathe and there is no improvement after taking albuterol 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		
		MEDICATION	HOW MUCH	WHEN
GREEN	REEN ZONE: WELL No cough, wheeze, chest tightness, or shortness of breath during the day or night			Before Exercise ☐ Recess ☐ PE/Sports (not to exceed every 4 hours)
		DAILY CONTROLLER MEDICATION	HOW MUCH	WHEN
	Can do usual activities			
□ 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		

InJAC February 2015 InJAC.org