ASTHMA MANAGEMENT PLAN & AUTHORIZATION FOR MEDICATION

TO DE COMOLETED DV DADENT			
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 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 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 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 ZONE: WELL • No cough, wheeze, chest tightness, or shortness of breath during the day			Before Exercise Recess PE/Sports (not to exceed every 4 hours)
or shortness of breath during the day	DAILY CONTROLLER MEDICATION	HOW MUCH	WHEN
or night			
Can do usual activities			
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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		

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