

# ASTHMA ACTION PLAN & AUTHORIZATION FOR MEDICATION

Attachment I  
Regulation 757-5

**TO BE COMPLETED BY PARENT:**

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

Parent/Caregiver \_\_\_\_\_ Phone (H) \_\_\_\_\_ Phone (W) \_\_\_\_\_ Phone (Cell) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name of Physician/Nurse Practitioner/Physician Assistant \_\_\_\_\_ Office Phone ( ) \_\_\_\_\_  
Office Fax ( ) \_\_\_\_\_

**What triggers your child's asthma attack: (Check all that apply)**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Illness         | <input type="checkbox"/> Cigarette or other smoke   | Food _____   |
| <input type="checkbox"/> Emotions        | <input type="checkbox"/> Exercise/physical activity | Allergies: <input type="checkbox"/> Cat <input type="checkbox"/> Dog <input type="checkbox"/> Dust <input type="checkbox"/> Mold <input type="checkbox"/> Pollen |
| <input type="checkbox"/> Weather changes | <input type="checkbox"/> Chemical odors             | <input type="checkbox"/> Other _____   |

**Describe the symptoms your child experiences before or during an asthma episode: (Check all that apply)**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Cough               | <input type="checkbox"/> Tightness in chest  | <input type="checkbox"/> Rubbing chin/neck  |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Breathing hard/fast | <input type="checkbox"/> Feeling tired/weak |
| <input type="checkbox"/> Wheezing            | <input type="checkbox"/> Runny nose          | <input type="checkbox"/> Other _____        |

**TO BE COMPLETED BY HEALTH CARE PROVIDER:**

The child's asthma is:  Intermittent  Mild Persistent  Moderate Persistent  Severe Persistent  Exercise-Induced

Symptoms OR	Peak Flow Monitoring	Treatment		
<b>WELL</b> • Usual medications control asthma • No cough or wheeze • Able to sleep through the night • No rescue meds needed • No activity restrictions (PE & recess are okay)	<b>GREEN ZONE</b>  Personal Best = _____  to _____	<b>Controllers &amp; Relievers</b>		
		<input type="checkbox"/> Inhaled Corticosteroid		
		<input type="checkbox"/> Advair		
		<input type="checkbox"/> Symbicort		
		<input type="checkbox"/> Other		
		<b>Leukotriene Modifier:</b> Singulair		
<input type="checkbox"/> Other				
<b>Relievers</b>	<input type="checkbox"/> Albuterol (with spacer) or nebulizer	2 puffs 1 min. apart (or 1 nebulizer treatment) every 4-6 hrs. as needed	<input type="checkbox"/> 2 puffs or 1 nebulizer treatment 5 min. before physical activity	
<input type="checkbox"/> Other	Other			
<b>SICK</b> • Needs reliever medications more often • Increased asthma symptoms (shortness of breath, cough, chest pain) • Wakes at night due to asthma • Unable to do usual activities	<b>YELLOW ZONE</b>  to _____	1. <input type="checkbox"/> Continue daily controller medications 2. <input type="checkbox"/> Give albuterol 2-6 puffs (1 min. between puffs) with spacer or 1 nebulizer treatment, wait 20 min. 3. <input type="checkbox"/> If no improvement, repeat 2-6 puffs or 1 nebulizer treatment, wait 20 min. <b>Call parent and/or MD.</b>  <b>If no improvement, CALL 911</b>  <b>If child returns to Green Zone:</b> <input type="checkbox"/> Continue to give albuterol 2 puffs every 4 hours for 1 to 2 more days <input type="checkbox"/> No physical exercise <input type="checkbox"/> Physical exercise as tolerated i.e. PE & recess at school		
		<input type="checkbox"/> Give albuterol (2-6 puffs (with spacer) or 1 nebulizer treatment NOW! May repeat once after 20 min.  <b>If there is no improvement, call parent and/or 911.</b> <b>Call 911 immediately if:</b> • Child is struggling to breathe and there is no improvement 20 minutes after taking albuterol • Child has trouble talking or walking • Child has lips or fingernails that are gray or blue • Child's chest or neck is pulling in with breathing		
<b>EMERGENCY!</b> • Reliever medications do not help • Very short of breath • Constant cough	<b>RED ZONE</b>  < _____	<input type="checkbox"/> Give albuterol (2-6 puffs (with spacer) or 1 nebulizer treatment NOW! May repeat once after 20 min.  <b>If there is no improvement, call parent and/or 911.</b> <b>Call 911 immediately if:</b> • Child is struggling to breathe and there is no improvement 20 minutes after taking albuterol • Child has trouble talking or walking • Child has lips or fingernails that are gray or blue • Child's chest or neck is pulling in with breathing		

**PATIENT/STUDENT INSTRUCTIONS:**

- 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 is to notify his/her designated school health officials after using inhaler per school protocol  
 Student needs supervision or assistance to use his/her inhaler  Student shall **NOT** be able to carry his/her inhaler while at school

Valid for current school year

HEALTH CARE PROVIDER SIGNATURE \_\_\_\_\_ PLEASE PRINT PROVIDER'S NAME \_\_\_\_\_ DATE \_\_\_\_\_

I give permission for school personnel to follow this plan, administer medication and care for my child and contact my physician if necessary. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I approve this Asthma Management Plan for my child.

\_\_\_\_\_  
PARENT SIGNATURE

\_\_\_\_\_  
DATE

CINCH  
Virginia Asthma Coalition  
revision 3/07

cc: principal \_\_\_\_\_ office staff \_\_\_\_\_ librarian \_\_\_\_\_ cafeteria mgr. \_\_\_\_\_ bus driver/transportation \_\_\_\_\_ Coach/PE \_\_\_\_\_ teachers \_\_\_\_\_

RELEASE AND ACKNOWLEDGEMENT AGREEMENT BY PARENTS  
OF CIVIL IMMUNITY FOR SCHOOL BOARDS AND SCHOOL EMPLOYEES

I/WE UNDERSTAND THAT the Code of Virginia §8.01-226.5:1 grants civil immunity for school boards and school employees who, in good faith, without compensation, supervise the self-administration of inhaled asthma medications by a student. The Prince William County School Board and Prince William County school employees shall not be liable for any civil damages for acts or omissions resulting from supervising the self-administration of inhaled asthma medications by students.

IT IS FURTHER AGREED AND UNDERSTOOD that it is my/our responsibility to ensure that the medicine is properly labeled as to its nature and the means of administration. It is also my/our responsibility to ensure that the medicine is fresh and adequately stored, and that an adequate supply is available at school. If the dosage changes or the medication is to be stopped prior to the time noted in the prescription, it is my/our responsibility to communicate the change clearly, in writing, to school staff.

I/WE CONSENT to the above conditions and acknowledge that Prince William County Public Schools is acting as my/our agent in supervising self-administration of asthma medication by my/our child.

I/WE FURTHER STATE that this release and acknowledgement agreement has been carefully read and I/WE know of the contents thereof and have signed the same by my/our own free act.

CAUTION: READ BEFORE SIGNING BELOW

Medication requested to be self-administered: \_\_\_\_\_

\_\_\_\_\_  
Name of Parent/Guardian (Printed)

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Child's Name (Printed)

\_\_\_\_\_  
Date

(This agreement must be signed and returned to the building principal before medication can be administered.)