

**ASTHMA CARE PLAN**

(To be completed by Parent and CDYS Nurse or CHN)

Date \_\_\_\_\_

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

Parent or Guardian \_\_\_\_\_

Daytime Phone Number - Mother \_\_\_\_\_

Father \_\_\_\_\_

<b>Emergency Contact:</b> _____	<b>Phone:</b> _____
<b>Name of Physician:</b> _____	<b>Phone:</b> _____

Has your child been hospitalized for Asthma? YES NO If yes, Date of last admission: \_\_\_\_\_

What are your child's asthma triggers? \_\_\_\_\_

List symptoms that signal an episode of asthma in its early stages: \_\_\_\_\_

List symptoms that signal an episode of asthma has progressed and requires parental or medical intervention: \_\_\_\_\_

Actions to take until child's parents arrive, or medical intervention is available: \_\_\_\_\_

**Peak Flow**

Personal Best _____	Green Zone: _____	Yellow Zone: _____	Red Zone: _____
Comments: _____			

**DAILY MEDICATION INFORMATION**

MEDICATION	DOSE	ROUTE	TIME	SIDE EFFECTS
1.				
2.				
3.				
4.				

**PRN MEDICATIONS**

PRN MEDICATION	DOSE	ROUTE	WHEN TO GIVE	SIDE EFFECTS

ADDITIONAL INSTRUCTIONS: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

CDYS personnel trained and authorized to administer medication:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

I \_\_\_\_\_ hereby authorize the CDYS personnel listed above to administer medication in the quantity and manner as requested and release the same from all legal claims due to injury or illness which may result from such administering.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

CDYS nurse or CHN Signature: \_\_\_\_\_

SNRT reviewed date \_\_\_\_\_ if disapproved, please explain: \_\_\_\_\_

doctor

ASTHMA ACTION PLAN

For use of this form see MEDCOM Cir 40-7

PATIENT IDENTIFICATION

GREEN ZONE: Doing Well

Take these Long-Term-Control Medicines each day (Includes an anti-inflammatory)

No cough, wheeze, chest tightness, or shortness of breath during the day or night.

Medicine

How much to take

When to take it

Can do usual activities

And if a peak flow meter is used, peak flow more than

(80% or more of my best peak flow)

My best peak flow is:

Before exercise . . . . .  \_\_\_\_\_  2 or  4 puffs, 5 to 60 minutes before exercise

YELLOW ZONE: Asthma is Getting Worse

1st → Add: Quick-Relief Medicine and keep taking your GREEN ZONE medicine

Cough, wheeze, chest tightness, or shortness of breath or

2 or  4 puffs, every 20 minutes for up to 1 hour

(short-acting beta-agonist)

Nebulizer, once

Waking at night due to asthma, or

2nd → If symptoms (and peak flow, if used) return to GREEN ZONE after 1 hr of above treatment:

Can do some, but not all, usual activities

Take the quick-relief medicine every 4 hours for 1 to 2 days.

Double the dose of your inhaled steroid for \_\_\_\_\_ (7-10) days.

- OR -

Peak flow: \_\_\_\_\_ to \_\_\_\_\_

(60% - 80% of my best peak flow)

- OR -

If symptoms (and peak flow, if used) do not return to GREEN ZONE after 1 hour of above treatment:

Take \_\_\_\_\_  2 or  4 puffs or  Nebulizer (short acting beta-agonist)

Add \_\_\_\_\_ mg. per day for \_\_\_\_\_ (3-10) days. (oral steroid)

Call your Healthcare Provider within \_\_\_\_\_ hours after taking the oral steroid.

RED ZONE: Medical Alert!

Take this medicine:

Vary short of breath, or

\_\_\_\_\_  4 or  6 puffs or  Nebulizer (short acting beta-agonist)

Quick-relief medicines have not helped, or

\_\_\_\_\_ mg. (oral steroid)

Cannot do usual activities, or

Symptoms are same or get worse after 24 hours in Yellow Zone

- OR -

Then call your Healthcare Provider - NOW! Go to the hospital or call for an ambulance if:

Peak flow: less than is: \_\_\_\_\_

(< 60% of my best peak flow)

You are still in the red zone after 15 minutes and using your nebulizer AND

You have not reached your Healthcare Provider

DANGER SIGNS!

||||| → Take  4 or  6 puffs of your quick-relief medicine AND

Trouble walking/talking due to shortness of breath

Go to the hospital or call for an ambulance \_\_\_\_\_ NOW!

Lips or fingernails are blue

HEALTHCARE PROVIDER'S NAME: \_\_\_\_\_  
HEALTHCARE PROVIDER'S PHONE # \_\_\_\_\_  
HOSPITAL/EMERGENCY ROOM PHONE # \_\_\_\_\_  
I have read, understand, and have been given a copy of this Action Plan.

(Patient's Signature)

(Date)

doctor

MEMORANDUM FOR RECORD

**SUBJECT: Exception to Medical Policy for the Administrations of Routine and PRN Asthma Medication**

1. This Medical Exception to Policy will allow the storage and administration of both routine and PRN (as needed) asthma medications for the identified child in the CYS. This Medical Exception to Policy must be signed by the physician to be valid and will remain valid for one calendar year unless the child's condition changes. Additionally, an Asthma Care Plan will be completed by the parent and CYS nurse or CHN.

Child's Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

Personal Best Peak Flow Number: \_\_\_\_\_

Peak Flow Zones: Green Zone \_\_\_\_\_ Yellow Zone \_\_\_\_\_ Red Zone \_\_\_\_\_

Guidelines for performing Peak Flow monitoring: \_\_\_\_\_

**PRESCRIBED ROUTINE MEDICATIONS**

Name	Dose	Route	Time/Frequency
1. _____			
2. _____			
3. _____			

**PRESCRIBED PRN MEDICATIONS**

Name	Dose	Route	Frequency
1. _____			
2. _____			
3. _____			

Specific instructions for administration of PRN medication: \_\_\_\_\_

Possible side effects: \_\_\_\_\_

2. The following procedures must be followed by all personnel and sponsors in order for the above medication to be administered by CYS personnel or FCC provider.

a. A current Medical Health Assessment (which addresses asthma) must be completed by the child's physician before medication can be given at CYS facilities or FCC home.

b. A conference will be held with Parent, CYS nurse or CHN, and members of the Special Needs Resource Team.

c. If the above child is alert, exhibits no skin color changes and has symptoms of respiratory difficulty such as an excessive dry cough, mild wheeze, chest tightness, shortness of breath, rapid breathing, mild chest retraction, one of the child's parents or emergency designee must be contacted immediately. The symptoms will be described and the parent or emergency designee will give permission verbally that they wish the medication to be given. In the event the parent or designee is unable to be contacted one dose will be administered and efforts will be continued to contact the guardian.

d. If the child's condition does not improve within 10 minutes after administration of the medication one of the child's parents will be called to pickup the child.

e. **EMERGENCY PROCEDURES** will be initiated if the child experiences any of the following signs or symptoms: Severe wheeze; cough; shortness of breath, that gets progressively worse even after allowing the medication time to work; or if the child's lips or fingernails turn gray or blue.

f. When a child has asthma symptoms an ACCIDENT/UNUSUAL OCCURRENCE form will be completed stating the symptoms, when the parent was contacted, their guidance and when/if symptoms subsided.

g. Only one dose of any PRN asthma medication will be given per day.

h. A Medication Dispensation Authorization Form (DA Form 5225-R) must be completed. With each administration of any PRN asthma medication, justification for giving the medication must be listed on the back of the form. The medication dispensation authorization form will be reviewed each month.

1. Staff will be trained on the administration of the above listed medication during initial orientation, annually and interim thereafter.

j. Parents will provide staff with both verbal and written instruction on administration of their child's inhaler or nebulizer. CYS nurse and/or CHN will ensure that their procedure is within CYSD standard of care. Written instructions will be attached to the Medical Dispensation Form for staff review.

k. Follow-up conference with the Health Consultant, CYS or FCC staff, and parents are required if there is a change in the child's health, e.g. hospitalization, changes in medications or increased frequency of PRN medication administration.

\_\_\_\_\_  
CYS nurse or CHN      Date

\_\_\_\_\_  
Physician                      Date

\_\_\_\_\_  
Parent/Guardian      Date

\_\_\_\_\_  
CYS Director                      Date