

ASTHMA TREATMENT PLAN
PARENT CONSENT & PHYSICIAN ORDER (back side)

Name of Child _____ D.O.B _____

Please rate the severity your child's asthma. (circle) (not severe) 0 1 2 3 4 5 6 7 8 9 10 (severe)

What is your child's most common sign or symptom of having a problem with his/her asthma?

Coughing wheezing Shortness of breath Chest tightness Other _____

What medication(s) does your child take and how often? _____

What, if any, side effects have your child had from his/her medication? _____

Does your child do peak flows? ___yes ___no How often? _____

Does your child know his/her personal best rate? ___yes ___no Personal Best is _____

In the past year:

Has your child been treated in the emergency room for asthma? ___yes ___no # times _____

Has your child been hospitalized overnight or longer for asthma? ___yes ___no # times _____

If your child suffers an asthma attack in school, that is not relieved by medication or rest, you will be contacted immediately and if needed the ambulance will be called to transport your child to the Cooley Dickinson emergency room. Is there another course of action you would prefer? ___yes ___no

If yes, please describe _____

I consent to the medication order(s) and treatment plan as prescribed by my child's physician on the backside of this form. If my child has any changes in his/her asthma status or treatment, I will notify the school nurse immediately and provide new written instructions and orders if needed.

Parent Signature _____ Date _____

Thank you for your time and assistance. Our school fax number is 268-8420 our phone is 268-8421.

Please have the physician complete the section below and the backside of this sheet.

This two-sided form will serve as a parent consent, physician's order, and treatment plan for the administration of asthma medication(s) during school hours.

My office has instructed _____ in the proper way to use his/her medications.

It is my professional opinion that _____ should be allowed to carry and use that medication by him/herself if allowed during school hours.

I have instructed _____ in the proper way to use his/her peak flow meter.

Physician Signature

Date

Asthma Action Plan



General Information:

Name _____
 Emergency contact _____ Phone numbers _____
 Physician/Health Care Provider _____ Phone numbers _____
 Physician Signature _____ Date _____

Severity Classification	Triggers	Exercise
<input type="radio"/> Mild Intermittent <input type="radio"/> Moderate Persistent <input type="radio"/> Mild Persistent <input type="radio"/> Severe Persistent	<input type="radio"/> Colds <input type="radio"/> Smoke <input type="radio"/> Weather <input type="radio"/> Exercise <input type="radio"/> Dust <input type="radio"/> Air pollution <input type="radio"/> Animals <input type="radio"/> Food <input type="radio"/> Other _____	1. Pre-medication (how much and when) _____ 2. Exercise modifications _____

Green Zone: Doing Well

Peak Flow Meter Personal Best = _____

Symptoms

- Breathing is good
- No cough or wheeze
- Can work and play
- Sleeps all night

Control Medications

Medicine	How Much to Take	When To Take It
_____	_____	_____
_____	_____	_____
_____	_____	_____

Peak Flow Meter

More than 80% of personal best or _____

Yellow Zone: Getting Worse

Contact Physician if using quick relief more than 2 times per week.

Symptoms

- Some problems breathing
- Cough, wheeze or chest tight
- Problems working or playing
- Wake at night

Continue control medicines and add:

Medicine	How Much to Take	When To Take It
_____	_____	_____
_____	_____	_____
_____	_____	_____

Peak Flow Meter

Between 50 to 80% of personal best or _____ to _____

IF your symptoms (and peak flow, if used) return to Green Zone after one hour of the quick relief treatment, THEN

- Take quick-relief medication every 4 hours for 1 to 2 days
- Change your long-term control medicines by _____
- Contact your physician for follow-up care

IF your symptoms (and peak flow, if used) DO NOT return to the GREEN ZONE after 1 hour of the quick relief treatment, THEN

- Take quick-relief treatment again
- Change your long-term control medicines by _____
- Call your physician/Health Care Provider within _____ hours of modifying your medication routine

Red Zone: Medical Alert

Ambulance/Emergency Phone Number: _____

Symptoms

- Lots of problems breathing
- Cannot work or play
- Getting worse instead of better
- Medicine is not helping

Continue control medicines and add:

Medicine	How Much to Take	When To Take It
_____	_____	_____
_____	_____	_____
_____	_____	_____

Peak Flow Meter

Between 0 to 50% of personal best or _____ to _____

Go to the hospital or call for an ambulance if

- Still in the red zone after 15 minutes
- If you have not been able to reach your physician/health care provider for help
- _____

Call an ambulance immediately if the following danger signs are present

- Trouble walking/talking due to shortness of breath
- Lips or fingernails are blue