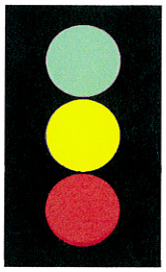
This form is not in compliance with CT DPH Daycare Licensing regulation 19a-79-9a, and Section 19a-79-9a Administration of Medications. Order From an Authorized Prescriber/Parent's Permission

Asthma Action Plan
Ages 0 – 11 Years

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
www.ct.gov/dph/asthma

Name:	Birth Date:	Date:
Parent/Guardian Phone #'s:	Provider Phone #: Fax #: (or stamp)	



Important! Things that make your asthma worse (Triggers): ☒ smoke ☐ pets ☐ mold ☐ dust ☐ tree/grass/weed pollen ☐ colds/viruses ☐ exercise ☐ seasons: other:

Severity Classification: ☐ Severe Persistent ☐ Moderate Persistent ☐ Mild Persistent ☐ Intermittent

GO – You're Doing Well!

USE THESE MEDICINES EVERY DAY TO PREVENT SYMPTOMS

You have *all* of these:
- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work and play

Peak Flow may be useful for some kids.

CONTROLLER MEDICINE _____ **DIRECTIONS** _____

_____ _____

☐ **If your child usually has symptoms with exercise then give:**

_____ _____

☺ **Inhalers work better with spacers. Always use with a mask when prescribed.**

CAUTION – Slow Down!

Continue with Green Zone Medicine and Add:

You have *any* of these:
- **First signs of a cold**
- Exposure to known trigger
- Cough
- Wheeze
- Tight chest
- Coughing at night

RESCUE MEDICINE _____ **DIRECTIONS** _____

_____ _____

Then: Wait **20 minutes** and see if the treatment(s) helped
- If you are **GETTING WORSE** or **NOT IMPROVING** after the treatment(s) **GO TO RED ZONE**
- If you are **BETTER,** continue treatments every 4 to 6 hours as needed for 24 to 48 hours

Then: If you still have symptoms after 24 hours, CALL YOUR DOCTOR and if he/she agrees:
- Start: _____

If rescue medication is needed more than 2 times a week, call your doctor at: _____

DANGER – Get Help!

TAKE THESE MEDICINES AND SEEK MEDICAL HELP NOW!

Your asthma is getting worse fast:
- Medicine is not helping
- Breathing is hard and fast
- Nose opens wide
- Can't talk well
- Getting nervous

RESCUE MEDICINE _____ **DIRECTIONS** _____

_____ _____

Then: Wait 15 minutes and see if treatment helped
- If **GETTING WORSE** or **NOT IMPROVING,** go to the hospital or **call 911**
- If you are getting **BETTER**, continue treatments every 4 to 6 hours and call your doctor – **say you are having an asthma attack and need to be seen TODAY!**

Then: **If your doctor agrees, start:** _____

✓ Make an appointment with your primary care provider within **two days** of an **emergency visit, hospitalization**, or anytime for **ANY** problem or question with asthma

School Nurse: Call provider for control concerns or if rescue medication is used more than 2 times/week for asthma symptoms

Parents: Call your doctor for control concerns or if rescue medication is used more than 2 times/week for asthma symptoms

HEALTHCARE PROVIDER SCHOOL MEDICATION AUTHORIZATION REQUIRED FOR _____ **as stated** *in accordance with CT State Law and Regulations 10-212a*

Self-Administration: ☐ This student **is** capable to safely and properly self-administer this medication **OR** ☐ This student **is not** approved to self-administer this medication

Signature: _____ **Provider Printed Name:** _____ **Date:** _____ **For use from** _____ **to** _____

Parent/Guardian Consent: REQUIRED

☐ I authorize this medication to be administered by school personnel **OR** ☐ I authorize the student to possess and self-administer medication.

I also authorize communication between the prescribing health care provider, the school nurse, the school medical advisor and school-based clinic providers necessary for asthma management and administration of this medication.

Parent/Guardian Signature: _____ **Date:** _____

*** Bring asthma meds and spacer to all visits**

Authorization for the Administration of Medication by School, Child Care, and Youth Camp Personnel

In Connecticut schools, licensed Child Day Care Centers and Group Day Care Homes, licensed Family Day Care Homes, and licensed Youth Camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the State Statutes and Regulations. Parents/guardians requesting medication administration to their child shall provide the program with appropriate written authorization(s) and the medication before any medications are administered. Medications must be in the original container and labeled with child's name, name of medication, directions for medication's administration, and date of the prescription.

Authorized Prescriber's Order (Physician, Dentist, Optometrist, Physician Assistant, Advanced Practice Registered Nurse or Podiatrist):

Name of Child/Student _____ Date of Birth____/____/____ Today's Date____/____/____

Address of Child/Student _____Town_____

Medication Name/Generic Name of Drug_____ Controlled Drug? YES NO

Condition for which drug is being administered: _____

Specific Instructions for Medication Administration _____

Dosage_____Method/Route_____

Time of Administration _____ If PRN, frequency_____

Medication shall be administered: Start Date: _____/_____/_____ End Date: _____/_____/_____

Relevant Side Effects of Medication _____ None Expected

Explain any allergies, reaction to/negative interaction with food or drugs_____

Plan of Management for Side Effects _____

Prescriber's Name/Title _____ Phone Number (_____) _____

Prescriber's Address _____ Town _____

Prescriber's Signature _____ Date _____/_____/_____

****

Parent/Guardian Authorization:

- ✓ I request that medication be administered to my child/student as described and directed above
- ✓ I hereby request that the above ordered medication be administered by school, child care and youth camp personnel and I give permission for the exchange of information between the prescriber and the school nurse, child care nurse or camp nurse necessary to ensure the safe administration of this medication.
- ✓ I have administered at least one dose of the medication with the exception of emergency medications to my child/student without adverse effects. (For child care only)

Parent/Guardian Signature_____ Relationship_____ Date ____/____/____

Parent /Guardian's Address _____Town_____State_____

Home Phone # (_____) _____-_____ Work Phone # (_____) _____-_____ Cell Phone # (_____) _____-_____

********** **SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL** **********

Self-administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the school nurse (if applicable) in accordance with board policy. In a school, inhalers for asthma and cartridge injectors for medically-diagnosed allergies, students may self-administer medication with only the written authorization of an authorized prescriber and written authorization from a student's parent or guardian or eligible student.

Prescriber's authorization for self-administration: ☐YES ☐NO _____ _____
Signature Date

Parent/Guardian authorization for self-administration: ☐YES ☐NO _____ _____
Signature Date

STAFF approval for self-administration: ☐YES ☐NO _____ _____
Signature Date

Today's Date _____ Printed Name of **ROSCCO STAFF** Receiving Written Authorization_____

Date _____ Printed Name of **Site Coordinator** Receiving Medication_____

_____ **Site Coordinator Signature**