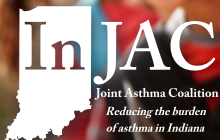


Back To School Asthma Checklist



- 1** Make an appointment with your child's health care provider for an annual asthma check-up, prescription updates, and a current **ASTHMA MANAGEMENT PLAN (AMP)**.
- 2** Provide updated asthma information, medications, and the AMP to the school nurse.
- 3** Help your child understand their triggers, their asthma attack symptoms, and where to go for help.
- 4** Make sure sitters, teachers, coaches and other caregivers understand that your child has asthma, how it is best controlled and what to do in the event of an asthma attack.
- 5** Arrange for your child to get the flu vaccine. Seasonal colds and flu increase the risk of asthma attacks!



Plan to have a **GREAT** school year!

For more questions, please visit our website at www.INJAC.org

NEED A PLAN

ASTHMA MANAGEMENT PLAN & AUTHORIZATION FOR MEDICATION

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 _____
 Emergency Contact _____ Relationship _____
 Phone (____) _____
 Asthma Care Provider _____
 Office Phone (____) _____ Office Fax (____) _____
 Office E-mail _____
(please mark best contact)

TO BE COMPLETED BY ASTHMA CARE PROVIDER		RESCUE (quick-relief) MEDICATION: _____															
	MONITORING	TREATMENT															
RED	RED ZONE: DANGER SIGNS <ul style="list-style-type: none"> 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 RED ZONE: EMERGENCY SIGNS <ul style="list-style-type: none"> Lips and fingernails are blue or gray Trouble walking and talking due to shortness of breath Loss of consciousness 	<ul style="list-style-type: none"> Give rescue medication: <input type="checkbox"/> 2 <input type="checkbox"/> 4 <input type="checkbox"/> 6 puffs (1 min between puffs) or 1 nebulizer treatment Call parent and/or Asthma Care Provider Call 911 NOW if: <ol style="list-style-type: none"> 1. Unable to reach medical care provider after arriving in the red zone 2. Child is struggling to breathe and there is no improvement after taking albuterol 3. 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	YELLOW ZONE: CAUTION <ul style="list-style-type: none"> Cough, wheeze, chest tightness, or shortness of breath, or Waking at night due to asthma, or Can do some, but not all, usual activities 	<ul style="list-style-type: none"> Continue daily controller medications Give rescue medication: <input type="checkbox"/> 2 <input type="checkbox"/> 4 <input type="checkbox"/> 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 _____ <p>• Parent/School Nurse: If needed, coordinate rescue medications to be given every 4 hours for <input type="checkbox"/> 2 <input type="checkbox"/> 3 days, if symptoms remain improved</p> <ul style="list-style-type: none"> If symptoms are not gone after <input type="checkbox"/> 2 <input type="checkbox"/> 3 days, move to the RED ZONE 															
GREEN	GREEN ZONE: WELL <ul style="list-style-type: none"> No cough, wheeze, chest tightness, or shortness of breath during the day or night Can do usual activities 	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%;">MEDICATION</th> <th style="width: 25%;">HOW MUCH</th> <th style="width: 25%;">WHEN</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td style="font-size: small;"> Before Exercise <input type="checkbox"/> Recess <input type="checkbox"/> PE/Sports <i>(not to exceed every 4 hours)</i> </td> </tr> <tr> <th>DAILY CONTROLLER MEDICATION</th> <th>HOW MUCH</th> <th>WHEN</th> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>	MEDICATION	HOW MUCH	WHEN			Before Exercise <input type="checkbox"/> Recess <input type="checkbox"/> PE/Sports <i>(not to exceed every 4 hours)</i>	DAILY CONTROLLER MEDICATION	HOW MUCH	WHEN						
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		Before Exercise <input type="checkbox"/> Recess <input type="checkbox"/> PE/Sports <i>(not to exceed every 4 hours)</i>															
DAILY CONTROLLER MEDICATION	HOW MUCH	WHEN															

- 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 _____