Community Colleges of Spokane

Spokane County Head Start/EHS
ASTHMA PLAN AND MEDICATION ORDERS

Attach Child's picture here

Nurse Consultant phone #: _____ Date Plan Developed/Revised/Reviewed _____

Child's Name:	Date of Birth:	Site Room/FSC
☐ History of anaphylaxis/severe reaction		
BRIEF MEDICAL HISTORY:		

ALL SECTIONS ON THIS PAGE TO BE COMPLETED BY CHILD'S LICENSED HEALTHCARE PROVIDER (LHP):

ASTHMA TREATMENT INSTRUCTIONS:

Asthma Triggers: ☐ None Known ☐ Animals ☐ Cold Air ☐ Exercise ☐ Pollens ☐ Respiratory colds

☐ Smoke, chemicals, strong odors ☐ Other _____ (i.e., foods, emotions, insects, etc.)

USUAL ASTHMA SYMPTOMS:

☐ Cough ☐ Wheeze ☐ Shortness of breath ☐ Chest tightness ☐ Asking to use inhaler ☐ Other _____

GO ZONE (GREEN) INFREQUENT/MINIMAL SYMPTOMS DO NOT LEAVE CHILD UNATTENDED

- Symptoms and/or use of quick relief medication < 2 times a week. (Does not include exercise pre-treatment usage.) Infrequent and minimal symptoms like cough, wheeze, short of breath.
- Full participation in physical activities.

CAUTION ZONE (YELLOW) CALL 911 DO NOT LEAVE CHILD UNATTENDED

- If Child is using the quick relief inhaler > 2 times a week or requires frequent observation by school staff ⇒**Notify parents + nurse**
- If Child is coughing, wheezing, and having difficulty breathing:
  - ❑ Give 2 puffs of quick relief inhaler. May repeat in 10 minutes. ⇒ **Notify parents + nurse if repeated.**
  - ❑ Other: _____
- Until symptoms are in the GO (green) ZONE, restrict strenuous physical activity.
- **If no improvement after repeated dose, CALL 911-See below**

STOP ZONE (RED) CALL 911 DO NOT LEAVE CHILD UNATTENDED

If Child is very short of breath, can see ribs during breathing, difficulty walking or talking, blue appearance to lips or nails, quick relief medication not working:

- **Call 911**

☐ Give 4 puffs quick relief inhaler (or nebulizer treatment) and notify parents and nurse
☐ This Child needs Epi auto-injector for severe asthma attacks and
☐ needs help giving the Epi auto-injector
☐ Other: _____

EXERCISE PRE-TREATMENT: (check all that apply) ☐ **N/A**

☐ Give 2 puffs of quick relief inhaler 15-30 minutes prior to ☐ Outside time ☐ Recess ☐ As needed with no less than 2 hours between doses unless Child complains of symptoms.
☐ May repeat 2 puffs of quick relief inhaler if symptoms occur. ⇒**Notify Nurse & Parent if occurs.**

Quick relief medication orders: (check the appropriate quick relief med(s) ☐ Uses inhaler with spacer

☐ Albuterol 2 puffs (Pro-air®, Ventolin HFA®, Proventil®) as needed every 4 hours for cough/wheeze
☐ Levalbuterol 2 puffs (Xopenex®) as needed every 4 hours for cough/wheeze
☐ Other _____ Epi auto-injector ☐ 0.3 mg ☐ Jr. 0.15 mg
☐ **Daily Controller meds:** _____ dose _____ time _____
☐ Takes daily controller medications at home

SIDE EFFECTS of medication(s): _____
☐ This Child demonstrated correct use of the inhaler in the LHP's office as required.

Start date: End date: (not to exceed current school year) ☐ Last day of school Other:

LHP Signature:	Print Name:
Date: Telephone #:	Fax #:

TO BE COMPLETED BY PARENT OR GUARDIAN:

EMERGENCY CONTACTS

Mother/Guardian	**Father/Guardian**
Name	Name
Home Phone	Home Phone
Work Phone	Work Phone
Other	Other

ADDITIONAL EMERGENCY CONTACTS

1.	Relationship:	Phone:
2.	Relationship:	Phone:

Parent:

- A new LHP Order/Emergency Care Plan (ECP) for Asthma and Parent/Child Agreement for an Inhaler/EpiPen must be submitted each year.
- I understand that if any changes are needed on the ECP, it is the parent's responsibility to contact the FSC.

I have reviewed the information on this Asthma Plan and Medication Orders and request/authorize trained Head Start/EHS employees to provide this care and administer the medications in accordance with the Licensed Healthcare Provider's (LHP's) instructions.

I authorize the exchange of medical information about my child's asthma between the LHP office and its Nurse Consultant.

Parent/Guardian Signature **Date**