ALL ABOUT ASTHMA

USEFUL INFORMATION, ACTION PLAN, AND SCHOOL FORMS

ACP
ADVOCATE COMMUNITY PROVIDERS

ALL ABOUT **ASTHMA**

What is Asthma?

Asthma is a disease of the lungs that can be controlled but not cured. Certain triggers, like cigarette smoke, may bring on an attack. If you live with or are around smokers, make sure they smoke outside.

When we inhale to breathe, air flows down our windpipe (trachea), through the air tubes (bronchi) and smaller airways, and into the air sacs (alveoli) in the lungs. Asthma causes the airways in our lungs to swell and create mucus, which makes it hard to breathe. If you cannot breathe well, everyday activities, exercise, and even walking may be very difficult. In severe circumstances, if not quickly treated, asthma can cause death.

What can I do to control my Asthma?

- ☑ With your doctor, complete an Asthma Action Plan (see sample included). Follow it every day. Bring a copy everywhere you go. Leave a copy at the places where you spend the most time, such as at home, work, school, and after-school programs.
- ☑ For schools, make sure to use the Department of Health Medication Administration form (see sample included) from your doctor.
- ☑ Use your asthma control medications, even when you feel well.
- ☑ Always carry your asthma rescue medications in case of an asthma attack.
- ☑ Identify and avoid triggers that may cause an asthma attack.
- ☑ Don't smoke and avoid others when they smoke.
- ☑ See your doctor if you have a cold, sinus infection, or other illness that makes you cough or affects your breathing.
- ☑ Get a flu shot every October.
- ☑ Wash your hands regularly to avoid flu germs.
- ☑ Talk to your doctor about a vaccine to prevent pneumonia (Pneumovax).

For Parents of School-Aged Children

- Request a meeting with your child's teachers, principal, and school nurse so they understand your child's needs and are prepared to respond to an emergency.
- Make sure your child uses control medication even if (s)he feels fine.
- Make sure your child always carries rescue medication in case of an asthma attack.
- Make sure your child's school nurse has a medication administration form allowing him/her to provide rescue medicines to your child if necessary.
- Tell your child's teachers, principal, and school nurse when your child is not feeling well.
- Make sure your child feels comfortable letting the teacher know when (s)he is not feeling well.

Asthma Action Plan

Date Completed

Name	Date of Birth	Grade/Teacher
Health Care Provider	Health Care Provider's Office Phone	Medical Record Number
Parent/Guardian	Phone	Alternate Phone
Parent/Guardian/Alternate Emergency Contact	Phone	Alternate Phone

DIAGNOSIS OF ASTHMA SEVERITY

☐ Intermittent ☐ Persistent [◯ Mild ◯ Moderate ◯ Severe]

ASTHMA TRIGGERS (Things That Make Asthma Worse)

☐ Smoke ☐ Colds ☐ Exercise ☐ Animals ☐ Dust ☐ Food
☐ Weather ☐ Odors ☐ Pollen ☐ Other _____

GREEN ZONE: GO!

Take These **DAILY CONTROLLER MEDICINES (PREVENTION)** Medicines **EVERY DAY**

You have ALL of these:
- Breathing is easy
- No cough or wheeze
- Can work and play
- Can sleep all night

☐ No daily controller medicines required

☐ Daily controller medicine(s):_____

☐ _____
Take _____ puff(s) or _____ tablet(s) _____ daily.

☐ For asthma with exercise, ADD: _____,
_____ puffs with spacer _____ minutes before exercise

ALWAYS RINSE YOUR MOUTH AFTER USING YOUR DAILY INHALED MEDICINE.

YELLOW ZONE: CAUTION!

Continue **DAILY CONTROLLER MEDICINES** and **ADD QUICK-RELIEF** Medicines

You have ANY of these:
- Cough or mild wheeze
- Tight chest
- Shortness of breath
- Problems sleeping, working, or playing

Take daily controller medicine if ordered and add this quick-relief medicine when you have breathing problems:

☐ _____ inhaler _____ mcg
Take _____ puffs every _____ hours, *if needed.* Always use a spacer, some children may need a mask.

☐ _____ nebulizer _____ mg /_____ ml
Take a _____ nebulizer treatment every _____ hours, *if needed.*

☐ Other _____

If quick-relief medicine does not HELP within _____ minutes, take it again and CALL your Health Care Provider

If using quick-relief medicine more than _____ times in _____ hours, CALL your Health Care Provider

IF IN THE YELLOW ZONE MORE THAN 24 HOURS, CALL HEALTH CARE PROVIDER.

RED ZONE: EMERGENCY!

Continue **DAILY CONTROLLER MEDICINES** and **QUICK-RELIEF** Medicines and **GET HELP!**

You have ANY of these:
- Very short of breath
- Medicine is not helping
- Breathing is fast and hard
- Nose wide open, ribs showing, can't talk well
- Lips or fingernails are grey or bluish

☐ _____ inhaler _____ mcg
Take _____ puffs every _____ hours, *if needed.* Always use a spacer, some children may need a mask.

☐ _____ nebulizer _____ mg /_____ ml
Take a _____ nebulizer treatment every _____ hours, *if needed.*

☐ Other _____

CALL HEALTH CARE PROVIDER AGAIN WHILE GIVING QUICK-RELIEF MEDICINE. If health care provider cannot be contacted, CALL 911 FOR AN AMBULANCE OR GO DIRECTLY TO THE EMERGENCY DEPARTMENT!

REQUIRED PERMISSIONS FOR ALL MEDICATION USE AT SCHOOL

Health Care Provider Permission: I request this plan to be followed as written. This plan is valid for the school year _____ – _____ .

Signature _____ Date _____

Parent/Guardian Permission: I give consent for the school nurse to give the medications listed on this plan or for trained school staff to assist my child to take them after review by the school nurse. This plan will be shared with school staff who care for my child.

Signature _____ Date _____

OPTIONAL PERMISSIONS FOR INDEPENDENT MEDICATION CARRY AND USE AT SCHOOL

Health Care Provider Independent Carry and Use Permission: I attest that this student has demonstrated to me that they can self-administer this rescue medication effectively and may carry and use this medication independently at school with no supervision by school personnel.

Signature _____ Date _____

Parent/Guardian Independent Carry and Use Permission (If Ordered by Provider Above): I agree my child can self-administer this rescue medication effectively and may carry and use this medication independently at school with no supervision by school personnel.

Signature _____ Date _____

COPY FOR PATIENT

ASTHMA MEDICATION ADMINISTRATION FORM

PROVIDER MEDICATION ORDER FORM—Office of School Health—School Year _____–_____

Student Last Name First Name Middle Initial

Date of Birth __ __ / __ __ / __ __ __ __ (M M D D Y Y Y Y) ☐ Male ☐ Female

Attach Student Photo To This Sheet

OSIS # __ __ __ __ __ __ __ __ __

DOE District __ __ Grade _____

School Name, Number, Address, and Borough:

The Following Section Completed By Student's **HEALTH CARE PRACTITIONERS**

Diagnosis
☐ Asthma

Control (*see NAEPP Guidelines*)
☐ Well Controlled
☐ Not Controlled
☐ Unknown

Severity (*see NAEPP Guidelines*)
☐ Intermittent
☐ Mild Persistent
☐ Moderate Persistent
☐ Severe Persistent

Student Asthma Risk Assessment Questionnaire (Y = Yes, N = No, U = Unknown)

History of near-death asthma requiring mechanical ventilation	☐Y	☐N	☐U	
History of life-threatening asthma (loss of consciousness or hypoxic seizure)	☐Y	☐N	☐U	
History of asthma-related PICU admissions (ever)	☐Y	☐N	☐U	
Received oral steroids within past 12 months	☐Y	☐N	☐U	____ times last : __ __ /__ __ /__ __
History of asthma-related ER visits within past 12 months	☐Y	☐N	☐U	____ times
History of asthma-related hospitalizations within past 12 months	☐Y	☐N	☐U	____ times
History of food allergy or eczema, specify: _____	☐Y	☐N	☐U	

Quick Relief In-School Medication (Select ONE)

☐ **Albuterol MDI** [*Ventolin® MDI can be provided by school for shared usage (plus individual spacer)*]:
[Parent must sign back]
☐ MDI w/ spacer
☐ DPI

☐ **Other**: Name: _____ Strength: _____
Dose: _____ Route: _____ Time Interval: ❑ ___ hrs

In-School Instructions

☐ **Standard Order:** Give 2 puffs/1 AMP q 4 hrs. PRN for coughing, wheezing, tight chest, difficulty breathing or shortness of breath ("asthma flare symptoms"). Monitor for 20 mins or until symptom-free. If not symptom-free within 20 mins may repeat **ONCE**.
If in Respiratory Distress*: Call 911 and give 6 puffs/1AMP; may repeat q 20 minutes until EMS arrives.

☐ **Pre-exercise:** 2 puffs/1 AMP 15-20 mins before exercise.

☐ **URI Symptoms or Recent Asthma Flare (within 5 days):** 2 puffs/1 AMP @ noon for 5 days.

Special Instructions:

Controller Medications for In-School Administration
(*Recommended for Persistent Asthma, per NAEPP Guidelines*)

☐ **Fluticasone MDI** [*Flovent® 110 mcg MDI can be provide by school for shared usage*]: **[Parent must sign back]**
☐ MDI w/ spacer
☐ DPI

☐ **Other**: Name: _____ Strength: _____
Dose: _____ Route: _____ Time Interval: ❑ ___ hrs

☐ **Standing Daily Dose:**
___ puffs/1AMP ONCE a day at ___ AM or ___ PM

Special Instructions:

Select the most appropriate option for this student:
☐ Nurse-Dependent Student: nurse must administer medication
☐ Supervised Student: student self-administers under adult supervision
☐ Independent Student: student is self-carry / self-administer (***Parent Initials Back*)

_____ Practitioner Initials

I attest student demonstrated the ability to self-administer the prescribed medication effectively for school / field trips / school sponsored events.

Home Medications (include over the counter)
☐ Reliever _____
☐ Controller _____
☐ Other _____

Health Care Practitioner Last Name First Name (Please Print) | Signature | Date __ __ /__ __ /__ __ __ __

Address | Tel. (_ _ _) _ _ _ - _ _ _ _ | Fax (_ _ _) _ _ _ - _ _ _ _ | NPI # _ _ _ _ _ _ _ _ _ _

Email Address | NYS License # **(Required)** | CDC and AAP strongly recommend annual influenza vaccination for all children diagnosed with asthma.

FAX COMPLETED FORMS TO 347-396-8945. INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS. REV 4/17 Turn to PAGE 2 ➔

FORMS CANNOT BE COMPLETED BY A RESIDENT

ASTHMA MEDICATION ADMINISTRATION FORM

ASTHMA PROVIDER MEDICATION ORDER—Office of School Health—School Year _____–_____

The Following Section To Be Completed By Student's **Parent/Guardian**

I hereby consent to the storage and administration of medication, as well as the storage and use of necessary equipment to administer medication, in accordance with the instructions of my child's health care practitioner. I understand that I must provide the school with the medication and equipment necessary to administer medication, including non-Ventolin inhalers. Medication is to be provided in a properly labeled original container from the pharmacy (another such container should be obtained by me for my child's use outside of school); the label on the prescription medication must include the name of the student, name and telephone number of the pharmacy, licensed prescriber's name, date and number of refills, name of medication, dosage, frequency of administration, route of administration and/or other directions; over the counter medications and drug samples must be in the manufacturer's original container, with the student's name affixed to that container. **I understand that all provided medication must be supplied in its original and UNOPENED medication box.** I further understand that I must immediately advise the school nurse of any change in the prescription or instructions stated above.

I understand that no student will be allowed to carry or self-administer controlled substances. I understand that this consent is only valid until the end of a New York City Department of Education ("DOE") sponsored summer instruction program session; or such time that I deliver to the school nurse a new prescription or instructions issued by my child's health care practitioner (whichever is earlier). By submitting this MAF, I am requesting that my child be provided specific health services by DOE and the New York City Department of Health and Mental Hygiene (DOHMH) through the Office of School Health (OSH). I understand that these services may include a clinical assessment and a physical examination by an OSH health care practitioner. Full and complete instructions regarding the above-requested health service(s) are included in this MAF. I understand that OSH and their agents, and employees involved in the provision of the above-requested health service(s) are relying on the accuracy of the information provided in this form. I understand that 30 days before the above-mentioned MAF expiration date, an OSH health care practitioner may examine my child to evaluate his/her asthma symptoms and my child's response to the prescribed medication, and may issue a new MAF. If the OSH health care practitioner determines that no changes to the orders in the MAF are necessary, the OSH health care practitioner may issue a new MAF with the same orders to expire in one year unless my child's health care practitioner provides a new MAF. If an OSH health care practitioner determines based on an examination of my child and pertinent medical history that the orders in the MAF should be changed, the OSH health care practitioner may issue a new MAF with different orders. I, along with my child's health care practitioner of record, will be notified of the issuance of new MAF and of any change in the MAF orders. I further understand that I will have until 30 days before the expiration date of this MAF to submit a new MAF, or to object to this examination in writing, to the school nurse. If I do not submit a new MAF to the school nurse, or notify the school nurse in writing that I object to my child being examined by an OSH health care practitioner, by this deadline, my child may be examined and a new MAF may be issued. I recognize that this form is not an agreement by OSH and DOE to provide the services requested, but rather my request/consent for such services. If it is determined that these services are necessary, a Student Accommodation Plan may also be necessary and will be completed by the school. I understand that OSH and DOE and their employees and agents, may contact, consult with and obtain any further information they may deem appropriate relating to my child's medical condition, medication and/or treatment, from any health care practitioner and/or pharmacist that has provided medical or health services to my child.

****SELF-ADMINISTRATION OF MEDICATION: Initial below for use of an epinephrine, asthma inhaler and other approved self-administered medications:**

☐ Parent Initials — I hereby certify that my child has been fully instructed and is capable of self-administration of the prescribed medication. I further consent to my child's carrying, storage and self-administration of the above-prescribed medication in school. I acknowledge that I am responsible for providing my child with such medication in containers labeled as described above, for any and all monitoring of my child's use of such medication, and for any and all consequences of my child's use of such medication in school. I understand that the school nurse will confirm my child's ability to self-carry and self-administer in a responsible manner. In addition, I agree to provide "back up" medication in a clearly labeled container to be kept in the medical room in the event my child does not have sufficient medication to self-administer.

☐ Parent Initials — I consent to the school nurse storing and/or administering to my child such medication in the event that my child is temporarily incapable of self-storage and self-administration of such medication.

☐ Parent Initials — I hereby certify that I have consulted with my child's health care practitioner and that I consent to the Office of School Health administering stock medication in the event that my child's asthma prescription medication is unavailable.

You must send your child's personal Metered Dose Inhaler (MDI) with your child on a school trip day so that he/she has it available. The stock medication is only for use while your child is in the school building.

SIGN HERE

Student Last Name	First	MI	Date of Birth __ __/__ __/__ __ __ __	School

Print Parent/Guardian's Name: _____ **Parent/Guardian's** Signature: _____

Date Signed __ __ / __ __ / __ __ __ __ Parent/Guardian's Address: Email:

Cell Phone (_ _ _) _ _ _ - _ _ _ _ Other Phone (_ _ _) _ _ _ - _ _ _ _ **Email:** _____

Alternate Emergency Contact Name: _____ Emergency Contact Phone: (_ _ _) _ _ _ - _ _ _ _

For OFFICE OF SCHOOL HEALTH (OSH) Only

Received By Name: _____ Date __ __/__ __/__ __ | Reviewed By Name: _____ Date __ __/__ __/__ __

Self-Administers/Self-Carries: ☐ Yes ☐ No
Supervised Student* ☐ Yes ☐ No

Services Provided By: ☐ Nurse ☐ School-Based Health Center ☐ OSH Public Health Advisor* ☐ OSH Asthma Case Manager*

Signature and Title (RN OR MD/DO/NP): _____ ☐ IEP

Revisions per Office of School Health after consultation with prescribing practitioner:

***Respiratory Distress**: includes breathlessness at rest, tachypnea, cyanosis, pallor, hunching forward, nasal flaring, accessory respiratory muscle use, abdominal breathing, shallow rapid breathing, mouthing words, wheezing throughout expiration and inspiration or decreased or absent breath sounds, agitation, drowsiness, confusion or exceptionally quiet appearance.

FAX COMPLETED FORMS TO 347-396-8945. Confidential information should not be sent by email. Rev 4/17

ADVOCATE COMMUNITY PROVIDERS

519 Eighth Avenue, 14th Floor
New York, NY 10018
1.844.ACP.PPS2
1.844.227.7772
acppps.org

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