I want to be able to: _____

_____

Children's
Healthcare of Atlanta
Dedicated to All Better

My asthma action plan

Patient name: _____ DOB: _____

Doctor's name: _____ Signature: _____

Doctor's phone #: _____ Date: _____

Controller medicines	How much to take	How often	Other instructions
-	-	____ times per day **EVERY DAY**	☐ Gargle or rinse mouth after use
-	-	____ times per day **EVERY DAY**	
-	-	____ times per day **EVERY DAY**	

Quick-relief medicines	How much to take	How often	Other instructions
-	☐ 2 puffs ☐ 4-6 puffs ☑ 1 nebulizer treatment	Take ONLY as needed (see below — starting in Yellow Zone or before excercise)	**NOTE: If you need this medicine more than 2 days a week, call your doctor.**

Asthma triggers (check all that apply):

❑ Exercise ❑ Change in temperature ❑ Molds ❑ Animals ❑ Strong odors or fumes ❑ Smoke
❑ Pollens ❑ Respiratory infections ❑ Dust ❑ Strong emotions ❑ Food/Other_____

Special instructions when I am ● *Doing well* ○ *Be careful* ● *Ask for help*

GREEN ZONE

Doing *well.*

- No coughing, wheezing, chest tightness, shortness of breath during the day or night
- Can go to school and play

PREVENT asthma symptoms every day:

- ☐ Take my controller medicines (above) every day
- ☐ Before exercise, take _____ puff(s) of _____
- ☐ Avoid triggers that make my asthma worse (See above)

YELLOW ZONE

Be *careful.*

- Coughing, wheezing, chest tightness, shortness of breath
- Waking at night due to asthma symptoms
- Can do some, but not all, usual activities
- Runny nose, watery eyes

CAUTION. Continue taking my controller medicines every day.

- ☐ Take _____ puffs or _____ nebulizer treatment(s) of quick relief medicine. If I am not back in the ***Green Zone*** within one hour, then I should:
- ☐ Continue using quick relief medicine every 4 hours as needed. Call provider if not improving in _____ days.
- ☐ Increase _____
- ☐ Add _____

RED ZONE

Ask for *help.*

- Very short of breath
- Continual coughing
- Skin between ribs is pulling inwards
- Difficulty speaking without running out of breath
- Quick-relief medicines have not helped
- Symptoms same or worse after 48 hours in Yellow Zone

MEDICAL ALERT! Get help!

- ☐ Take quick-relief medicine:_____ puffs every _____ minutes and get help immediately.
- ☐ Take _____
- ☐ Call _____

If skin, fingernail or lip color is blue at any time:

Call 911 for help or go to the nearest Emergency Department

Always consult your child's doctor or other healthcare provider if you have any questions or concerns about the care or health of your child.
Children's Healthcare of Atlanta at Hughes Spalding is owned by Grady Health System® and managed by HSOC, Inc. an affiliate of Children's.

NEWTON COUNTY THEME SCHOOL

Authorization To Give Medication At School (PRN)

If medication can be given at home or after school hours, please do so. However, if medication must be given during school hours, this form must be completed. Please write one medication per page.
Student's Name: _____

Teacher: Grade: _____ I request that _____School, through the principal or designee supervise/assist in the administering of medication to my child, according to the instructions below. I understand that: • Medications must be in the original labeled container (no baggies, foil, etc.). Pharmacists can provide a duplicate labeled container with only the school doses. • Parent/guardian must provide specific instructions, as well as the medication and related equipment to the principal or clinic personnel. • It will be the responsibility of the parent/guardian to inform the school of any changes. New medication or new doses will not be given unless a new form is completed and a newly labeled container is provided. • All medication will be taken directly to the office/clinic by the parent/legal guardian. • Unused medication will be disposed of unless picked up within one week after medication is discontinued.

****

Name of Medication: _____

Dose: _____ Route (by mouth, topical, etc): _____

Time(s) to be given: _____ Stop Medication on: _____

Condition/Illness Requiring Medication: _____

Possible Side Effects, if any: _____

Physician's Name: _____ Physician's Phone: _____

I hereby authorize the personnel, employees and officials of the _____ School District to assist my child in taking prescribed medication according to district policy and I release them from any liability for administering this medication. I understand that, in the event of a change in medicine, I am responsible for presenting a new request form.

_____ Parent/ Legal Guardian signature Date

Home Phone_____ Work Phone_____Pager/Cell Phone

_____

_____

_____

To be completed by School Health Clinic Personnel only: Date received: _____ Name of Medication: _____ # Doses: _____

NEWTON COUNTY SCHOOL SYSTEM

2109 NEWTON DRIVE, N.E.
P.O. BOX 1469
COVINGTON, GEORGIA 30015
Phone: (770) 787-1330 * Fax (770) 784-2945

SAMANTHA M. FUHREY, Ed. S.
Superintendent

DARREN BERRY, Ed. S.
Director of Student Services

Date: _____ School : _____
Student: _____ Teacher: _____

Dear Parent or Guardian:

Upon reviewing the completed clinic card , it was noted that your child has a medical condition that may require medication/treatment at school.

_____ Asthma (possibly requiring the use of an inhaler)
_____ Allergy (possibly requiring the use of an Epi-pen (Epinephrine)
_____ Seizure disorder (possibly requiring Diastat)
_____ Other

Please sign and return this letter indicating at the bottom whether you intend to provide the medication and the appropriate paperwork will be sent home to be completed.

If you have any questions, please refer to the student handbook for the clinic and medications, policies, or feel free to contact your school Nurse.
Thank you in advance for your prompt attention to this matter.

_____ Yes, I will send in the medication and complete the paperwork required.
I understand No medication will be accepted without a completed Authorization to give Medication Form or Medical Careplan including **All** signatures and Medication Prescription label on medicine.

_____ No, I don't intend to provide the medication for my child to have during school hours.
I understand that the Newton County School System is not liable for any consequence of the medication not being available.

Parent signature: _____