The Greenwich Spanish School

6 Riverside Ave. #108-9 – Riverside, CT 06878 - Telephone (203) 637-8288

Dear GSS Parent:

Attached is an asthma packet with an Asthma Action Plan, a Special Care Plan and an Authorization for the Administration of Medication form. Please have your child's physician complete and sign the attached forms. The forms then need to be signed by a parent/guardian.

Please verify the following:

______ The original prescription label is affixed to the medication box

______ The prescription is current

______ The medication has a safety cap

______ Non-prescription medications are clearly labeled with your child's name, date of birth and prescribed dosage.

Please return your child's asthma packet along with your child's medication to The Greenwich Spanish School prior to your child returning to school. Thank you for your prompt cooperation.

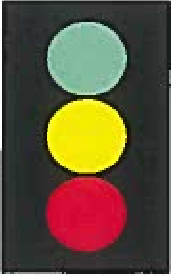
Sincerely,

Katie Attubato, Nurse Practitioner

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)		

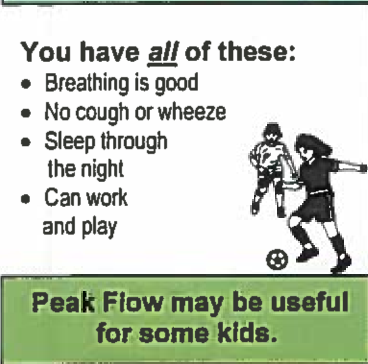


Important! Things that make your asthma worse (Triggers): ☒ smoke ☐ pets ☐ mold ☐ dust ☐ tree/grass/weed pollen ☐ colds/viruses ☐ exercise ☐ seasons: other:

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.

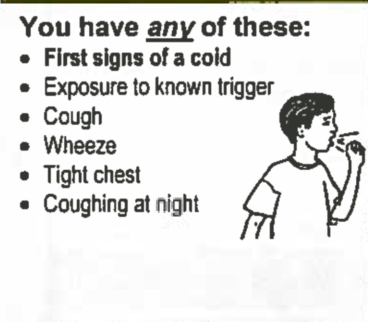
CONTROLLER MEDICINE	DIRECTIONS

☐ **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

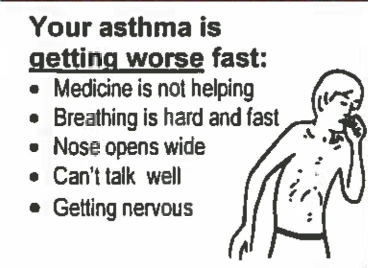
Then: Wait **20 minutes** and see if the treatment(s) helped
- ➢ If you are **GETTING WORSE** or **NOT IMPROVING** after the treatment(s) **GO TO RED ZONE**
- ➢ If you are **BETTER**, continue treatments every 4 to 6 hours as needed for 24 to 48 hours

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

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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.

Form I

Special Care Plan for a Child with Asthma

Child's Name:________________________ **Date of Birth:**__________
Parent(s) or Guardian(s) Name:______________________________
Emergency phone numbers: Mother______________ Father______________
(see emergency contact information for alternate contacts if parents are unavailable)
Primary health provider's name: __________ **Emergency Phone:** ______________
Asthma specialist's name (if any): __________ **Emergency Phone:** ______________

Known triggers for this child's asthma (circle all that apply):

colds
house
excitement
mold
dust
weather changes
exercise
strong odors
animals
tree pollens
grass flowers
smoke
room deodorizers
foods (specify): ____________________________
other (specify): ______________________________________

Activities for which this child has needed special attention in the past (circle all that apply)

outdoors
field trip to see animals
running hard
gardening
jumping in leaves
outdoors on cold or windy days
playing in freshly cut grass

indoors
kerosene/wood stove heated rooms
art projects with chalk, glues, fumes
sitting on carpets
pet care
recent pesticides application in facility
painting or renovation in facility

other (specify):____

Can this child use a **flowmeter** to monitor need for medication in child care? NO YES
personal best reading: ________________ reading to give extra dose of medicine:________
reading to get medical help:______________
How often has this child needed urgent care from a doctor for an attack of asthma:
in the past 12 months?________________ in the past 3 months?________________

Typical signs and symptoms of the child's asthma episodes (circle all that apply):

fatigue
breathing faster
restlessness,agitation
face red, pale or swollen
wheezing
dark circles under eyes
grunting
sucking in chest/neck
persistent coughing
complaints of chest pain/tightness
flaring nostrils, mouth open (panting)
gray or blue lips or fingernails
difficulty playing, eating, drinking, talking

Reminders:

1. *Notify parents immediately if emergency medication is required.*
2. *Get emergency medical help if:*
- the child does not improve 15 minutes after treatment and family cannot be reached
- after receiving a treatment for wheezing, the child:
  - is working hard to breathe or grunting
  - is breathing fast at rest (>50/min)
  - has trouble walking or talking
  - has nostrils open wider than usual
  - has sucking in of skin (chest or neck) with breathing
  - won't play
  - has gray or blue lips or fingernails
  - cries more softly and briefly
  - is hunched over to breathe
  - is extremely agitated or sleepy

3. *Child's doctor & child care facility should keep a current copy of this form in child's record.*

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Form I

Special Care Plan for a Child with Asthma (Continued)

Medications for routine and emergency treatment of asthma for: Child's name _______ Date of Birth _______			
Name of medication			
When to use (e.g., symptoms, time of day, frequency, etc.)	*routine or emergency*	*routine or emergency*	*routine or emergency*
How to use (e.g.,by mouth, by inhaler, with or without spacing device, in nebulizer, with or without dilution, diluting fluid, etc.)			
Amount (dose) of medication			
How soon treatment should start to work			
Expected benefit for the child			
Possible side effects, if any			
Date instructions were last updated by child's doctor	Date: _______ Name of Doctor (print): _______ Doctor's signature: _______		
Parent's permission to follow this medication plan	Date: _______ Parent's signature: _______		

If more columns are needed for medication or equipment instruction, copy this page

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Authorization for the Administration of Medication by Child Day Care Personnel

In Connecticut, licensed Child Day Care Centers, Group Day Care Homes and Family Day Care Homes 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 by daycare staff shall provide the program with appropriate written authorization(s) and the medication before any medications are dispensed. 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. All unused medication will be destroyed if not picked up within one week following the termination of the authorized prescriber's order.

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

Name of Child ____________________ Date of Birth ____/____/____ Today's Date ____/____/____

Medication Name ____________________ Controlled Drug? ☐ YES ☐ NO

Dosage ______________ Method ______________ Time of Administration ______________

Specific Instructions for Medication Administration ____________________

Medication Administration Start Date _____/_____/_____ Stop Date _____/_____/_____

Is this medication to be self-administered by the child? ☐ Yes ☐ No

Relevant Side Effects of Medication ____________________

Plan of Management for Side Effects ____________________

Known Food or Drug: Allergies? ☐ YES ☐ NO Reactions to? ☐ YES ☐ NO Interactions with? ☐ YES ☐ NO

If "yes" to any of the above, please explain ____________________

Prescriber's Name ____________________ Phone Number (_____)______________

Prescriber's Address ____________________ Town ______________

Signature ____________________

Parent/Guardian Authorization:

☐ I request that medication be administered to my child as described and directed above and attest that **I have administered at least one dose of the medication to my child without adverse effects.**

☐ I request that medication be self-administered to my child as described and directed above.

Name of Day Care Program ____________________ Today's Date _____/_____/_____

Child's Name ______________ Address ______________ Town ______________

Name of Parent/Guardian Authorizing Administration of Medication ____________________

Relationship to Child: ☐ Mother ☐ Father ☐ Guardian/Other explain: ______________

Address ______________ Town ______________ Phone Number (_____) ______________

Signature of Parent/Guardian Authorizing Administration of Medication ____________________

Name of Childcare Personnel Receiving Written Authorization and Medication ______________

Title/Position ______________ **Signature (in ink)** ____________________