

# RESPIRATORY MEDICAL ACTION PLAN

(to be completed by Health Care Provider)

Child's Name

Date of Birth

CYSS Program/Activity

Sponsor Name

Health Care Provider

Health Care Provider Phone

## Asthma Triggers

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Respiratory illness   | <input type="checkbox"/> Animals          | <input type="checkbox"/> Excessive play or exercise | <input type="checkbox"/> Temperature/season/humidity changes |
| <input type="checkbox"/> Tobacco smoke         | <input type="checkbox"/> Molds            | <input type="checkbox"/> Emotion/anxiety            | <input type="checkbox"/> Others _____                        |
| <input type="checkbox"/> Strong odors or fumes | <input type="checkbox"/> Chalk dust/dust  | <input type="checkbox"/> Food: _____                |  |
| <input type="checkbox"/> Pollens               | <input type="checkbox"/> Dust mites       |   |  |
| <input type="checkbox"/> Grass                 | <input type="checkbox"/> Stinging insects |   |  |

## Signs and Symptoms

- |   |  |
|---|--|
| <input type="checkbox"/> Excessive dry cough  | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Wheezing(a whistling sound when child breaths)                   | <input type="checkbox"/> Tightness in chest  |
| <input type="checkbox"/> Mild chest retraction(child is pulling in chest while breathing) |  |

## Treatment Protocol

- Administer Rescue Med as prescribed
- If 2 puffs indicated per prescription, give one minute apart
- Stay with youth/child
- Contact parents/guardian

## Emergency Response

**IF THIS HAPPENS  
GET EMERGENCY  
HELP NOW!  
CALL 911**

- Hard time breathing with:
- Chest and neck pulled in with breathing
  - Child is hunched over
  - Child is struggling to breathe
  - Trouble walking or talking
  - Stops playing and can't start activity again
  - Lips and fingernails are gray or blue

## Follow Up

This Asthma Medical Action Plan will be updated/revised whenever medications or child's health status changes. If there are no changes the Asthma Medical Action Plan will be updated at least every 12 months.

## Date of Registration Renewal

DATE: YYYYMMDD: \_\_\_\_\_

## RESPIRATORY MEDICAL ACTION PLAN ADDITIONAL CONSIDERATIONS

(to be completed by Health Care Provider)

### Medications for Asthma

For children requiring rescue medication, the medication is required to be at program site at all times while child is in care. For youth who self-medicate and carry their own medications, medication must be with the youth at all times. The options of storing "back up" rescue medications at program is available.

### Field Trip Procedures

Rescue medications should accompany child during any off-site activities.

- The child should remain with staff or parent/guardian during the entire field trip.      Yes    No
- Staff members on trip must be trained regarding rescue medication use and this health care plan.  
This plan must accompany the child on the field trip.
- Other (specify) \_\_\_\_\_

### Self-Medication for School Age/Youth

**YES.** Youth can self-medicate. I have instructed \_\_\_\_\_ in the proper way to use his/her medication. It is my professional opinion that he/she SHOULD be allowed to self administer his/her medication. Youth has been instructed not to share medications and should youth violate these restrictions the privilege of self medicating will be revoked and the youth's parents notified.

OR

**NO.** It is my professional opinion that \_\_\_\_\_ SHOULD NOT carry or self administer his/her medication.

### Bus Transportation should be alerted to child's condition.

- This child carries rescue medications on the bus.      Yes    No
- Rescue medications can be found in:    Backpack    Waistpack    On Person    Other \_\_\_\_\_
- Child will sit at the front of the bus.              Yes    No
- Other (specify): \_\_\_\_\_

### Sports Events/Instructional Programs

Parents are responsible for having rescue medication on hand and administering it when necessary when the child is participating in any CYS sports/instructional activity. Volunteer coaches and instructors do not administer medications.

### Parental Permission/Consent

Parent's signature gives permission for child/youth personnel who have been trained in medication administration by the APHN to administer prescribed medicine and to contact emergency medical services if necessary. I also understand my child must have required medication with him/her at all times when in attendance at CYS programs.

### Youth Statement of Understanding

I have been instructed on the proper way to use my medication. I understand that I may not share medications and should I violate these restrictions, my privileges may be restricted or revoked, my parents will be notified and further disciplinary action may be taken. I am also required to notify staff when carrying or taking my medication.

#### I agree with the plan outlined above.

Printed Name of Parent/Guardian	Parent Signature	Date (YYYYMMDD)
Printed Name of Youth	Youth Signature	Date (YYYYMMDD)
Stamp of Health Care Professional	Health Care Professional Signature	Date (YYYYMMDD)
Printed Name of Army Public Health Nurse	Army Public Health Nurse Signature	Date (YYYYMMDD)