Asthma Treatment Plan

For: ______________________________ Child's Date of Birth: ________________

Today's Date: _________________ Patient's Phone Number: ___________________

Asthma Severity is: (Circle one)	**Intermittent**	**Mild Persistent**	**Moderate Persistent**	**Severe Persistent**

Daily Treatment Plan: Have your child take **all** of these medicines **everyday** even when your child feels well.

Albuterol: 1 vial premix (0.083%) solution in the nebulizer machine as needed and 15 minutes before exercise. **OR**
______ puffs as needed and 15 minutes before exercise at home and at school.

For increased coughing, wheezing, or exercise symptoms (not related to illness):
Albuterol 1 vial premix (0.083%) solution in the nebulizer machine
OR 2 puffs with spacer as needed

Sick Treatment Plan: Begin the Sick Treatment Plan if your child has a cough, wheeze, shortness of breath, or tight chest. Have your child take **all** of these medicines when your child is sick. After all cough, wheeze, shortness of breath, or tight chest have gone away use your child's sick plan for 5 more days. Then go back to your child's Daily Treatment Plan.

Albuterol: 1 vial premix (0.083%) solution four times/day and 2 more times at night if needed. **OR**
___ puffs four times/day and 2 more times at night if needed.

Emergency Plan: If the asthma attack is not getting better after your child has been on the Sick Treatment Plan for **2** days, or in case of emergency, call the office.

Your next asthma follow-up appointment is on:

_________________ Date	___________ Time	_________________________________ Clinician Name

Was a copy of the Asthma Treatment Plan and Asthma Trigger Form given to family? Yes No
Make sure you mark the appropriate asthma triggers on the reverse side.

Provider Signature ________________________________
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.

Healthcare Provider School Medication Authorization Required for ______________________ as stated *in accordance with CT State Law and Regulations 10-212a*
This child may self-administer their medication at school. YES NO Parents Initials_____________
Medication authorized from: __________________________ to: _________________________________
Signature:________________________________ Provider Printed Name:____________________
Side effects:__________________________________ or ☐Not expected Medication Allergies:_________________ or ☐NKDA
Parent/Guardian to complete this section:
I, _______________________________________ give permission to the school nurse to administer and delegate the administration of the medications provided to the school as noted above. I furthermore give permission to the nurse and/or the school-based health clinic to otherwise assist in the asthma management of my child. I also authorize communication between the prescribing health care provider, the school nurse, the school medical advisor and school-based health clinic providers necessary for asthma management and administration of this medication.
_________________ **(Parent/guardian signature) Date:__________________**