ASTHMA MANAGEMENT AND MEDICATION ADMINISTRATION PROTOCOL
(To Be Completed by Child's PARENT AND PHYSICIAN)

Child's Name:_____ Date of Birth:_____

Provider Name:_____ Telephone:_____

Has a medical provider diagnosed your child with asthma? Yes □ No □

How many asthma attacks has your child had in the past: Month? _____ Year? _____

Has your child ever been hospitalized for asthma? Yes □ No □

Please list all of the things that may trigger an asthma attack in your child: _____

_____

Does your child take medication for asthma? Yes □ No □ If yes, name of medication_____

Is medication needed at school? Yes □ No □

EMERGENCY ACTION FOR NO MEDICATIONS: Call CONTACT, IF UNAVAILABLE CALL 911.

EMERGENCY ACTION is necessary when child has symptoms such as:_____

_____

_____

MEDICATIONS should be administered by Head Start Staff when:_____

_____

Give MEDICATIONS as follows:

Name of Medication	Method of Administration	Dosage	Frequency of Use - When to Use

Check for decreased symptoms and/or improved breathing.

Check for possible side effects such as:_____

Allow child to stay at Head Start if:_____

Seek EMERGENCY MEDICALCARE if Emergency Contacts are unavailable and child has any one of the following: (Check "✓"all that apply)

- o No improvement minutes after initial treatment with medication.
- o Hard time breathing with:
  - Chest and neck pulled in with breathing.
  - Child hunched over with breathing.
  - Child struggling to breath.
- o Trouble walking or talking.
- o Stops playing and cannot start activity again.
- o Lips or fingernails are gray or blue.

Special Instructions:_____

_____

I request and authorize that the above named student be administered the above identified medication in accordance with the instructions indicated above for the period commencing with the_____day of_____, 20___, through the_____day of_____,20____, as there exists a valid health reason which makes administration of the medication advisable during school hours or during such time that the student is under the supervision of school officials. Such medication may be administered by medically untrained school personnel.

Physician Signature:_____ Date:_____

My signature below signifies consent for UMCHS staff to administer asthma medication to my child in accordance with the doctor's prescription for the period commencing with the_____day of_____, 20___, through the_____day of_____,20____, Not to exceed one school year.

Parent Signature:_____ Date:_____

Child/Family Advocates are responsible for ensuring substitute staff are informed of procedures outlined within this Asthma Management Plan.
Maintain completed original in Center File with copies to the Emergency Contact Binder and HSD.