

**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 Doctor diagnosed your child with Asthma ?		YES	NO
How severe would you rate your child's Asthma? (Make a check "✓" in the box that applies most.)			
Not Severe	Somewhat Severe	Very Severe	Life Threatening
How many Asthma attacks has your child had in the past:		Month?	Six months?
		One year?	Lifetime?
Has your child ever been hospitalized for Asthma?		YES	NO
		If "YES," when?	
Identify all of the things that trigger an Asthma attack in your child:		Animals	Dust Mites
		Chalk Dust	
Change in temperature	Smoke	Molds	Pollens
			Strong Odors
Respiratory Infections	Chemicals	Food	Other (Please describe)
Does your child take any medication for asthma?		YES	NO
		Is medication needed at school?	
		Yes	No
If medication administration is needed at school, please identify the settings where medication is necessary: (Check " " all that apply.)			
Classroom	Bus	Outside Activities	Field Trips
Other Settings (Please Describe)			

**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)**

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