(NOT A REAL PROTOCOL)

ASTHMA MANAGEMENT AND MEDICATION ADMINISTRATION PROTOCOL

(To Be Completed by Child's PARENT AND PHYSICIAN)

Child's Name: Pedro Estevan Date of Birth: 8/22/05

Provider Name: Dr Smith Telephone: 567-2945

Has a Medical Doctor diagnosed your child with Asthma ?	X	YES		NO							
How severe would you rate your child's Asthma? (Make a check "✓" in the box that applies most.)											
	Not Severe		X	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		X	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	X	Strong Odors		Bee Stings/Insects	
Respiratory Infections	X	Chemicals		Food		Other (Please describe)					
Does your child take any medication for asthma?		YES		NO	Is medication needed at school?		X	Yes		No	
If medication administration is needed at school, please identify the settings where medication is necessary. (Check "□" all that apply.)											
X	Classroom	X	Bus	X	Outside Activities	X	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: severy coughing, wheezing, gasping for air

MEDICATIONS should be administered by Head Start Staff when: any of above symptoms occur

Give MEDICATIONS as follows:

Name of Medication	Method of Administration	Dosage	Frequency of Use - When to Use
Albuterol	MDI	2 puffs	every 4-6 hours as needed

Check for decreased symptoms and/or improved breathing.

Check for possible side effects such as: ↑ pulse rate

Allow child to stay at Head Start if: Improves

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 19 day of 8, 2009, through the 19 day of 8, 2010, 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: (Providers Signature) Date: 8/19/09

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 19 day of 8, 2009, through the 19 day of 8, 2010, Not to exceed one school year.

Parent Signature: Juanita Esteven Date: 8/26/09

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.