Here is the Asthma Care Plan to be filled out by your doctor.

There is also the Medication Administration Authorization Form. Make a separate copy of this form for each medication that the doctor prescribes for your child.

This needs to be turned in AT LEAST one week before your camp session begins, along with the medication/s.

Thank you

First Aid Director

Day Camp
Asthma Action Plan

Name: ___________________________ Date: ___________________________

Birth Date: ___________________________ Provider Phone #: ___________________________

Provider Fax #: ___________________________ Parent/Guardian Phone #: ___________________________

Patient Goal: ___________________________ Severity: ___________________________

Important! Things that make your asthma worse: (Triggers) ☐ dust ☐ pets ☐ mold ☐ smoke ☐ pollen ☐ other ________

Severity: ☐ Severe Persistent ☐ Moderate Persistent ☐ Mild Persistent ☐ Mild Intermittent

GO -- You're Doing Well! Use these medicines everyday:

PERSONAL BEST PEAK FLOW: __________

You have all of these:
• Breathing is good
• No cough or wheeze
• Sleep through the night
• Can work and play

OR Peak flow from ________ to ________

MEDICINE HOW MUCH HOW OFTEN / WHEN

CAUTION -- Slow Down! Continue with green zone medicine and add:

You have any of these:
• First signs of a cold
• Exposure to known trigger
• Cough
• Mild wheeze
• Tight Chest
• Coughing at night

OR Peak flow from ________ to ________

MEDICINE HOW MUCH HOW OFTEN / WHEN

CALL YOUR HEALTH CARE PROVIDER: ___________________________

DANGER -- Get Help! Take these medicines and call your provider now.

Your Asthma is getting worse fast:
• Medicine is not helping
• Breathing is hard and fast
• Nose opens wide
• Ribs show
• Can't talk well

OR Peak flow less than ________

MEDICINE HOW MUCH HOW OFTEN / WHEN

Get help from a provider now! Do not be afraid of causing a fuss. Your provider will want to see you right away. It's important! If you cannot contact your provider, go directly to the emergency room and bring this form with you. DO NOT WAIT.

Make an appointment with your primary care provider within two days of an ED visit or hospitalization.

Provider Signature: ___________________________ Date: ___________________________

PARENT/GUARDIAN TO COMPLETE THIS SECTION:

I, ___________________________, give permission to the school nurse and/or the school-based health clinic to exchange information and otherwise assist in the asthma management of my child including direct communication with my child's primary care provider ___________________________. Date: ___________________________

( parent/guardian name—please print)
( parent/guardian signature)

REFER TO THE BACK OF THE LAST PAGE FOR THE MEDICATION AUTHORIZATION FORM
Authorization for the Administration of Medication by School, Child Care, and Youth Camp Personnel

In Connecticut schools, licensed Child Day Care Centers and Group Day Care Homes, licensed Family Day Care Homes, and licensed Youth Camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the State Statutes and Regulations. Parents/guardians requesting medication administration to their child shall provide the program with appropriate written authorization(s) and the medication before any medications are administered. Medications must be in the original container and labeled with child's name, name of medication, directions for medication's administration, and date of the prescription.

Authorized Prescriber's Order (Physician, Dentist, Optometrist, Physician Assistant, Advanced Practice Registered Nurse or Podiatrist):

Name of Child/Student __________________________ Date of Birth _____ / _____ Today's Date _____ / _____
Address of Child/Student __________________________ Town __________________________
Medication Name/Generic Name of Drug __________________________ Controlled Drug? ☐ YES ☐ NO
Condition for which drug is being administered: _______________________________________

Specific Instructions for Medication Administration

Dosage __________________________ Method/Route __________________________
Time of Administration __________________________ If PRN, frequency __________________________
Medication shall be administered: Start Date: _____ / _____ / _______ End Date: _____ / _____ / _______

Relevant Side Effects of Medication _____________________________________ ☐ None Expected
Explain any allergies, reaction to/negative interaction with food or drugs: ______________________________________

Plan of Management for Side Effects

Prescriber's Name/Title __________________________ Phone Number (_____) __________________________
Prescriber's Address __________________________ Town __________________________
Prescriber's Signature __________________________ Date _____ / _____ / _______

School Nurse Signature (if applicable) __________________________

Parent/Guardian Authorization:

☐ I request that medication be administered to my child/student as described and directed above

☐ I hereby request that the above ordered medication be administered by school, child care and youth camp personnel and I give permission for the exchange of information between the prescriber and the school nurse, child care nurse or camp nurse necessary to ensure the safe administration of this medication. I understand that I must supply the school with no more than a three (3) month supply of medication (school only).

☐ I have administered at least one dose of the medication with the exception of emergency medications to my child/student without adverse effects. (For child care only)

Parent/Guardian Signature __________________________ Relationship __________________________ Date _____ / _____ / _______
Parent/Guardian's Address __________________________ Town __________________________ State __________________________
Home Phone # (_____) _______ Work Phone # (_____) _______ Cell Phone # (_____) _______

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the school nurse (if applicable) in accordance with board policy. In a school, inhalers for asthma and cartridge injectors for medically-diagnosed allergies, students may self-administer medication with only the written authorization of an authorized prescriber and written authorization from a student's parent or guardian or eligible student.

Prescriber's authorization for self-administration: ☐ YES ☐ NO __________________________ Signature __________________________ Date __________________________

Parent/Guardian authorization for self-administration: ☐ YES ☐ NO __________________________ Signature __________________________ Date __________________________

School nurse, if applicable, approval for self-administration: ☐ YES ☐ NO __________________________ Signature __________________________ Date __________________________

Today's Date ___________ Printed Name of Individual Receiving Written Authorization and Medication __________________________

Title/Position __________________________ Signature (in ink or electronic) __________________________

Note: This form is in compliance with Section 10-212a, Section 19a-79-9a, 19a-87b-17 and 19-13-B27a(v.)
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*Medication authorization form must be used as either a two-sided document or attached first and second page.

- Authorization form is complete
- Medication is appropriately labeled
- Medication is in original container
- Date on label is current

Person Accepting Medication (print name) ___________________________ Date _____ / _____ / _____