CYS SERVICES SNAP RESPIRATORY MEDICAL ACTION PLAN

(to be completed by Health Care Provider)

Child/Youth's Name	Date of Birth	Date

Sponsor Name

Health Care Provider	Health Care Provider Phone

Triggers (mark all that apply)

- □ Chalk dust/dust
- □ Dust mites
- □ Respiratory illness
- □ Tobacco smoke
- □ Food: _____
- □ Stinging insects
- □ Strong odors/fumes
- □ Animals
- □ Molds
- □ Temperature/season/humidity changes
- □ Pollens
- □ Grass
- □ Excessive play/exercise
- □ Anxiety
- □ Others: _____

Medication is necessary when the child/youth has symptoms such as: (check all that apply)

- □ Excessive dry cough
- □ Shortness of breath
- □ Tightness in the chest
- □ Wheezing (a whistling sound when the child breathes)
- □ Mild chest retraction (child is "pulling in" chest while breathing)
- □ Other:
- □ Other:

Medication/Treatment Plan

Medication/Strength:

_____

Route: □ Inhaler □ Inhaler with Spacer □ Nebulizer

If using inhaler Give: _____Puff(s)_____Minute(s) apart □ May Repeat one time in ___ minutes if Symptoms persist

□ Do Not Repeat

- **Administer rescue medication as prescribed and give courtesy call to parent**
- **Stay with child/youth** *for 20 minutes*
- **Contact parents/guardian for child pick-up** *if needing to give total 4+ puffs, or develops emergency symptoms as below*

Emergency Response

IF THIS HAPPENS ⇨
GET EMERGENCY HELP NOW
CALL 911

- Hard time breathing with:
  - Chest and neck pulled in with breathing
  - Child/Youth is hunched over
  - Child/Youth is struggling to breathe
- Trouble walking or talking
- Stops playing and can't start activity again
- Lips and fingernails are gray or blue

Follow Up

This Medical Action Plan must be updated/revised whenever medications or child/youth's health status changes. If there are no changes, the Medical Action Plan must be updated every 12 months.

Form Updated 11 Jun 12

Name

RESPIRATORY MEDICAL ACTION PLAN ADDITIONAL CONSIDERATIONS

(to be completed by Health Care Provider)

Medications

For children requiring rescue medication, the medication is required to be at program site at all times while child is in care. For youth who self-medicate and carry their own medications, medication must be with the youth at all times. The options of storing "back up" rescue medications at program is available.

Field Trip Procedures

Rescue medications should accompany child during any off-site activities.

- The child/youth should remain with staff or parent/guardian during the entire field trip. □ Yes □ No
- Staff members on trip must be trained regarding rescue medication use and this health care plan.
- This plan must accompany the child on the field trip
- Other: _____

Self Medication for School Age Youth

□ **YES** Youth can self medicate. I have instructed _____in the proper way to use His/her medication. It is my professional opinion that he/she **SHOULD** be allowed to carry and self administer his/her medication. Youth have been instructed not to share medications and should youth violate these restrictions, the privilege of self medicating will be revoked and the youth's parents notified. Youth are required to notify staff when carrying medication.

□ **NO** It is my professional opinion that _____ **SHOULD NOT** carry or self administer his/her medication.

Bus Transportation should be Alerted to Child/Youth's Condition.

- This child/youth carries rescue medications on the bus. □ Yes □ No
- Rescue medications can be found in: □ Backpack □ Waist pack □ On Person □ Other: _____
- Child/youth should sit at the front of the bus. □ Yes □ No
- Other: (specify) _____

Sports Events/Instructional Programs

Parents are responsible for having rescue medication on hand and administering it when necessary when the child/youth is participating in any CYS sports/instructional activity. Volunteer coaches/instructors do not administer medications.

Parental Permission/Consent

Parent's signature gives permission for child/youth personnel who have been trained in medication administration by the APHN to administer prescribed medicine and to contact emergency medical services if necessary. I also understand my child/youth must have required medication with him/her at all times when in attendance at CYS programs.

Youth Statement of Understanding

I have been instructed on the proper way to use my medication. I understand that I may not share medications and should I violate these restrictions, my privileges may be restricted or revoked, my parents will be notified and further disciplinary action may be taken. I am also required to notify staff when carrying or taking my medication.

I agree with the plan outlined above.

Printed Name of Parent/Guardian	Parent/Guardian Signature	Date (YYYYMMDD)
Printed Name of Youth (if applicable)	Youth Signature	Date (YYYYMMDD)
Stamp of Health Care Provider	Health Care Provider Signature	Date (YYYYMMDD)
Printed Name of Army Public Health Nurse	Army Public Health Nurse Signature	Date (YYYYMMDD)