

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)

- | | | |
|--|--|--|
| <input type="checkbox"/> Chalk dust/dust | <input type="checkbox"/> Stinging insects | <input type="checkbox"/> Pollens |
| <input type="checkbox"/> Dust mites | <input type="checkbox"/> Strong odors/fumes | <input type="checkbox"/> Grass |
| <input type="checkbox"/> Respiratory illness | <input type="checkbox"/> Animals | <input type="checkbox"/> Excessive play/exercise |
| <input type="checkbox"/> Tobacco smoke | <input type="checkbox"/> Molds | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Food: _____ | <input type="checkbox"/> Temperature/season/humidity changes | <input type="checkbox"/> Others: _____ |

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

- | | | |
|--|--|---|
| <input type="checkbox"/> Excessive dry cough | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Tightness in the chest |
| <input type="checkbox"/> Wheezing (a whistling sound when the child breathes) | | |
| <input type="checkbox"/> Mild chest retraction (child is "pulling in" chest while breathing) | | |
| <input type="checkbox"/> Other: | | |
| <input type="checkbox"/> 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 Do Not Repeat

- Administer rescue medication as prescribed
- Stay with child/youth
- Contact parents/guardian

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.

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 (This signature serves as the exception to medication policy)	Date (YYYYMMDD)