DEPARTMENT OF THE ARMY
DUNHAM U.S. ARMY HEALTH CLINIC
450 GIBNER ROAD, SUITE #1
CARLISLE BARRACKS, PENNSYLVANIA 17013-5086

RMAPS

This letter is intended to help you complete the paperwork for this child's attendance at Carlisle Barracks/Letterkenny's CYSS programs. The Medical Action Plan (MAPS) are very important for children that have **any** medical concerns. They are designed to communicate to the staff your instructions as to **how, why** and **when** to administer medications, which as you know, are part of the "7 Rights" of medication administration.

The instructions on this Respiratory MAP should match the instructions on the medication label **exactly**. The sole purpose of this MAP is to allow nonclinical staff to safely follow your orders to administer medications without any confusion.

Key Points:

Please fill MAP out in its **entirety**

- Please make sure front and back pages are complete
- Providers need to sign and stamp the back page
- If stamp does not include providers name and credentials, please print them

Under Triggers and symptoms:

- Please list **all** known potential triggers and symptoms when child needs medicated

Under Treatment plan:

- Please list the name of the medication only
- Indicate if a spacer is needed or if mode is via nebulizer
- If stated to repeat medication, please match the time **exactly** to the medication label.
- Please **do not write PRN** (means nothing to nonclinical people) - need to write out "as needed"
- No fluctuating time frames ie: 4-6 hours

Thank you for taking the time to complete this paperwork and for helping to keep our kids safe. If you have questions as to how to fill out these forms, please contact me at 717-961-2009.

Respectfully,

Jo Stepp
Public Health Nurse
Dunham Army Health Clinic
Ph: 717-961-2009
Fx: 717-961-2049

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

Administer the rescue med_____ as directed on prescription label on medication.

Route: □ Inhaler □ Inhaler with Spacer □ Nebulizer

□ May Repeat one time *in* _____ *minutes if symptoms still persist* □ 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.

Form Updated 21Jul 09

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)

Form Updated 21Jul 09