



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,

A handwritten signature in black ink that reads "Jo Stepp".

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)

<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

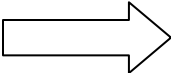
Administer the rescue med \_\_\_\_\_ as directed on prescription label on medication.

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

<p><b>IF THIS HAPPENS</b>  <b>GET EMERGENCY HELP</b> <b>NOW</b> <b>CALL 911</b></p>	<ul style="list-style-type: none"><li>• Hard time breathing with:<ul style="list-style-type: none"><li>○ Chest and neck pulled in with breathing</li><li>○ Child/Youth is hunched over</li><li>○ Child/Youth is struggling to breathe</li></ul></li><li>• Trouble walking or talking</li><li>• Stops playing and can't start activity again</li><li>• Lips and fingernails are gray or blue</li></ul>
--	---

## 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)