**Burlington Public Schools**

# Respiratory Action Plan

**Student:** _____ Date of Birth: _____ Weight: _____ Grade: _____ Homeroom: _____

My child has a respiratory condition. I will **not**_____ I will _____send my child's rescue/emergency medications to school. (Initial and sign at bottom of page. If medication is to be available in school, please have your prescriber complete the following).

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

Allergies: _____

Triggers of episode (check all that apply):

| | | |
|---|---|---|
| □ Allergies | □ Cold temperature | □ Molds/ Pollen |
| □ Animals | □ Emotions | □ Respiratory infections |
| □ Carpet | □ Exercise | □ Strong odors |
| □ Chalk dust | □ Food_____ | □ Weather changes |

## Health Care Provider Must Write Orders

### green-*go* Daily maintenance and/or preventative

| When to Use | | Medications | Dose | Route | Frequency | Side Effects |
|---|---|---|---|---|---|---|
| • No cough, wheeze, chest tightness, or shortness of breath<br>• Can do usual activities | Peak Flow _____ to | | | | | |
| • Breathing is good | | | | | | |

### yellow-*caution* Rescue Medication Continue "green zone" medicines

| When to Use | | Medications | Dose | Route | Frequency | Side Effects |
|---|---|---|---|---|---|---|
| • Cough, wheeze, chest tightness, or shortness of breath<br>• Waking at night due to cold asthma<br>• First sign of a cold | Peak Flow _____ to | | | | | |

- **If symptoms are the same after 24 hours or if your child needs Yellow Zone medicines 3 times per week or more, *contact his/her doctor***

### red-*danger* EMERGENCY Plan Take these medicines AND then call your doctor right away!

| When to Use | | Medications | Dose | Route | Frequency | Side Effects |
|---|---|---|---|---|---|---|
| • Trouble talking or walking<br>• Working hard to breathe<br>• Noisy breathing at rest | Peak Flow _____ to | | | | | |

### Call 911 or go to the nearest emergency room if:

- **You are struggling to breathe, nasal flaring, Lips or fingernails are blue**
- **You do not feel any better 15 minutes after you start the red zone medicines and you have not reached your doctor**

**This medication may be held for Field Trips: Yes _____ No _____**

**MD** (Print Name): _____ Phone Number: _____

**Prescriber's Signature** _____ Date: _____

*Signature must be manual; may not be rubber-stamped, according to the Commonwealth of Massachusetts Board of Registration in Medicine Prescribing Practices and Policy Guidelines adopted Aug. 1, 1989 and amended Dec. 12, 2001.*

Parent/Guardian _____/_____/_____/_____
(Print Name) (Home #) (Cell #) (Work #)

Parent/Guardian _____/_____/_____/_____
(Print Name) (Home #) (Cell #) (Work #)

Emergency Contact_____/_____/_____/_____
(Relationship to child) (Home #) (Cell #) (Work #)

**Please see additional consents on the back of this form**

# Respiratory Care Plan …continued

**Student:** _____ Date of Birth: _____ Weight: _____ Grade: _____ Homeroom: _____

---

**Field Trip-** In event of field trip: (Please initial all that apply)

_____ May omit medication for field trips.
_____ I or my designee will attend my child's field trips and assume responsibility of my child's medical & medication needs.
_____ My child may self-administer, after my child demonstrates competency, **(*Nurse must assess and evaluate "Yes" below)**. *Due to State Laws, a nurse cannot delegate assessment skills and/or the administration of "as needed" medications such as, but not limited to asthma related rescue medications.*

____Yes ____No I give the school nurse permission to share information relative to my child's respiratory condition with appropriate personnel, as necessary for my child's safety and health (i.e., need for inhaler, adverse side effects).

____Yes ____No I give the school nurse permission to speak to my child's prescriber concerning my child's respiratory health.

**Parent/Guardian's Signature**_____Date: _____

Please list all the medications the child currently takes *(if this changes at any time during the school year, please contact the school nurse):* _____

***Please note:*** *All medications must be in their original and/or pharmacy-labeled containers and delivered to the nurse by a responsible adult. They may be retrieved by the parent/guardian at any time. Medications will be disposed of if they are not picked up within one week following the order's termination or at the completion of the last day of school.*

---

## For Health Office Use Only

Student has demonstrated competency in medication self administration:

___Yes ___No _____Date Nurse's name printed: _____ Nurse's' signature: _____
___Yes ___No _____Date Nurse's name printed: _____ Nurse's' signature: _____
___Yes ___No _____Date Nurse's name printed: _____ Nurse's' signature: _____

Medication storage location: _____ Date Medication EXPIRES: _____