# Mercer Co. Schools

**Asthma Health Care Plan**

**Student's Name: _____Date of Birth:_____ Grade: _____**
**School:_____**

**Transportation: □ Bus AM_____ PM_____ □ Car □ Driver Allergies: _____**

**School Sponsored Sports & Activities your child is involved in: _____**

**Asthma Severity & Triggers_____**

| **Green Zone: Have the child take these medicines EVERY day, even when the child feels well. (Control Medications)** | |
|---|---|
| You have **ALL** of these:<br>• No cough, chest tightness, wheeze, or shortness of breath during the day or night.<br>• Can do usual activities | **Medications:** |
| **Yellow Zone: Begin the sick treatment plan if the child has a cough, wheeze, shortness of breath, or a tight chest. Have the child take all of these medicines when sick. (Control Medication & Quick-Relief)** | |
| You have **ANY** of these:<br>• Cough, wheeze, chest tightness, or shortness of breath.<br>• Waking at night due to asthma.<br>• Can do some, but not all, usual activities. | **Medications:**<br><br>**If the child is in the yellow zone for more than 24 hours or is getting worse, follow the RED zone and call the doctor.** |
| **Red Zone: EMERGENCY! If breathing is hard and fast, ribs sticking out, trouble walking, talking, or sleeping. (Control Medication, Quick Relief, and GET HELP!** | |
| You have **ANY** of these:<br>• Breathing is hard and fast<br>• Ribs sticking out<br>• Trouble walking, talking, or sleeping<br>• Blue lips or fingernails<br>• Tired or lethargic<br>• Medicine is not helping | **Medications:**<br><br>**If the student is not better right away, call 911.** |

## Exercise Induced Asthma Medication Order:

**PROVIDER INITIALS:**

_____This student is capable and approved to carry and self-administer the medicine(s) named above.

_____This student is NOT approved to carry or self-administer.

_____Other instructions as indicated: _____

**Provider Printed Name: _____Provider Signature:_____Date:_____**

**To Be Completed By Parent/Guardian**

I give permission for _____ to receive the above medication(s) or treatment at school according to standard school policy and expressly hold harmless and waive any liability on behalf of the school or its employees and agents concerning any injuries or reactions resulting from administration of the above medication unless such as the result of negligence or misconduct on behalf of the school or its employees. I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication to enable the physician's orders to be followed. I also give permission for this plan to be available for use in my child's school and for the nurse to contact the physician when necessary to carry out this plan.

**Signature of Parent/Guardian: _____ Date: _____**

**Phone Number(s) of Parent/Guardian: Cell_____ Work_____ Home_____**

**Other Emergency Contact Name:_____Phone:_____**

Staff Use Only: □ IC □ Teachers □ Bus □ Sports/Activities