NAUGATUCK PUBLIC SCHOOLS — Asthma Action Plan

Name:	**Phone:**	**D.O.B.**
Provider:	**Provider Phone#:**	**Fax #:**
Patient Goal:		**Severity:**
Asthma Triggers: ☐ Exercise ☐ Dust ☐ Pets ☐ Mold ☐ Smoke ☐ Pollen ☐ Viruses		

GO—You're Doing Well! — Use these medicines to prevent symptoms:

You have all of these:

- Breathing easy
- No cough or wheeze
- Sleep through the night
- Can work and play

OR

Peak Flow from Personal Best of _____ to _____

MEDICINE	HOW MUCH	HOW OFTEN/WHEN

CAUTION—Slow Down! — Continue with green zone medicine and add:

You have <u>any</u> of these:

- First signs of a cold
- Exposure to a known trigger
- Cough
- Mild wheeze
- Tight chest
- Coughing at night

OR

Peak Flow from _____ to _____

MEDICINE	HOW MUCH	HOW OFTEN/WHEN

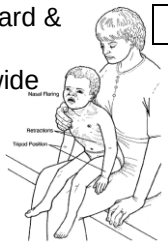
IF you use your inhaler in school, you MUST see your school nurse after you use your inhaler for evaluation of effectiveness.

DANGER—Get Help! — Take these medicines & call your provider NOW!

Your asthma is <u>getting worse</u> fast:

- Medicine is not helping
- Breathing is hard & fast
- Nose opens wide
- Ribs show
- Can't talk well

OR



Peak Flow Less Than _____

MEDICINE	HOW MUCH	HOW OFTEN/WHEN

Your condition is serious & you need to get help NOW! Your provider will want to know about this—do not delay calling for help. If you cannot reach your provider <u>right away</u>, you must go to the Emergency Room or call 911 IMMEDIATELY!

Provider's Name _____ **Signature** _____ **Date** _____

Medication authorized from _____ to _____ **Child May Self-Administer?** Yes N

Parent/Guardian complete this section:

I hereby give permission to the school nurse to administer and to delegate the administration of the medications provided to the school as noted above. I also give permission to the school nurse and/or school-based clinic to exchange information and otherwise assist in the asthma management of my child including direct communication with my child's primary care provider. I have circled YES below if I believe my child can administer his/her own medicine.

Parent/Guardian Name _____ **Signature** _____ **Date** _____

Telephone Number: (H) _____ **(C)** _____ **Child May Self-Administer?** Yes No