Buckeye Valley Local School District

Asthma Action Plan

Student name______________________Date of Birth________________ School year________________
Teacher__________________________ Grade____ Building: BVE BVW BVMS BVHS

updated ___/____/_______

Green Zone: Doing Well	Do these things every day!
If you hall ALL of these: • Breathing is good • No cough or wheeze • can work, play and exercise My Asthma Triggers to watch for: ______________________ ______________________ ______________________	Medication:_____________________ How much:_____________________ How often:_____________________

Yellow Zone: Symptoms Starting	Do these things to help relieve your symptoms
If you have any of these: • First signs of a cold • Repeated cough • Wheeze • Chest tightness • Fast breathing • Waking at night from cough	Medication:_____________________ How much:_____________________ How Often:_____________________ If symptoms do not go away or return in less than 4 hours. • GET HELP (see Orange and Red zones) • continue taking Green zone medications

Orange Zone: In Trouble	Call for Help!
Not improving or symptoms return too quickly--symptoms are mild. If you have ANY of these: • Cough, wheeze, chest tightness or fast breathing after quick-relief medicine • relief from quick-relief medicine doesn't last 4 hours • vomiting after coughing • kept awake most of the night by asthma symptoms • Quick-relief medicine is needed 4 or more times in a single day	**CALL 9-1-1** Call parent/guardian: Name:________________________ Relationship:___________________ Phone number:_________________ Name:________________________ Relationship:___________________ Phone Number:_________________ Medication:_______________________ How much:_______________________ How Often:_______________________

(Continued on back)

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Red Zone: In Danger	Go For Help!
Not improving or symptoms return too quickly--having trouble breathing If you have ANY of these: ● Breathing hard and fast (gasping) ● Rib and neck muscles show when breathing ● Hard to talk, walk, eat, or drink due to shortness of breath ● Nose opens wide when breathing ● Lips and fingernails turn gray or blue	**Call 9-1-1** Call parent/guardian: Name:_________________________ Relationship:____________________ phone number:__________________ Name:_________________________ Relationship:____________________ Phone number:__________________ On the way, also take: Medication:______________________ How much:______________________ How often:_______________________

Emergency Numbers

1. Doctor______________________________ Phone Number:_________________________________

2. Emergency Contacts:

Name	Relationship	Phone number (s)
a.______________________________	_______________________	________________________
b.______________________________	_______________________	________________________

✦Even if the parent/guardian can not be reached, DO NOT HESITATE to medicate as appropriate and/or call 911✦

Doctor Signature:____
Date:________________________________

I authorize an employee designated by the school board to administer the above medication. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. I also authorize the licensed healthcare professional to talk with the prescriber or pharmacist to clarify medication orders. I release and agree to hold the Board of Education, its officials and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization. Medication form must be received by the principal, his/her designee and/or the school nurse. I understand that the medication must be in the original container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration and the date of drug expiration when appropriate. This plan is effective for the above listed school year. It is the responsibility of Parent/Guardian to provide the school with a completed plan (signed by physician) at the start of each school year or as needed should any changes be made to the Asthma Action Plan.

Parent's Signature:____ Date:__________________