

**ROCHESTER COMMUNITY SCHOOLS
ASTHMA Care**

Child's picture
Face only

This form must be completed, signed, and ATTACHED to an Asthma Medical Action Plan (MAP). Your child's health care provider will choose to either use their own MAP template, OR the Allergy MAP template listed on the RCS website.

Student's Name: _____ School: _____
 Date of birth: _____ Age: _____
 Grade: _____ Teacher: _____

This MAP is validated with signatures and dates, by both the licensed health care provider (Doctor of Osteopathic Medicine, D.O., Medical Doctor, M.D., Nurse Practitioner, N.P., or Physician Assistant, P.A.), and a parent/legal guardian. Recommended orders for medical interventions within this treatment plan, will expire at the end of the 2023-2024 school year.

CONTACT INFORMATION

Call First:	Call Second:	Call Third:
Name:	Name:	Name:
Relationship:	Relationship:	Relationship:
Phone 1:	Phone 1:	Phone 1:
Phone 2:	Phone 2:	Phone 2:
Email:	Email:	Email:

For asthma symptoms, my child has/uses the following:

- YES NO Spacer (with or without a mask)
 YES NO Medication at home to control asthma

PARENT/GUARDIAN CONSENT

I, (parent/guardian), _____, request that my child, _____, receive the attached medical management at school, according to standard school policy. I authorize consent to the ordering licensed health care provider staff and school to share information, as needed, to clarify orders and to assist with my child's health care needs. I agree to have the information, in this entire plan, shared with individuals that need to know. Also, I give permission to use my child's picture on this plan (if I did not supply a photo).

YES NO I will supply the school with a back-up inhaler, if my child is to self-carry.

PARENT/GUARDIAN SIGNATURE: _____ Date: _____

Transportation Office Use ONLY if needed
 Bus # _____ Driver: _____ Route # _____ Medical File _____
 Auto-injector type: _____ School Office Use ONLY
 Expiration date: _____

Asthma Action Plan for Home & School



Name:

Birthdate:

Asthma Severity: Intermittent Mild Persistent Moderate Persistent Severe Persistent
 He/she has had many or severe asthma attacks/exacerbations

Green Zone Have the child take these medicines every day, even when the child feels well.

Always use a spacer with inhalers as directed.

Controller Medicine(s): _____

Controller Medicine(s) Given in School: _____

Rescue Medicine: Albuterol/Levalbuterol _____ puffs every four hours as needed

Exercise Medicine: Albuterol/Levalbuterol _____ puffs 15 minutes before activity as needed

Yellow Zone Begin the sick treatment plan if the child has a cough, wheeze, shortness of breath, or tight chest. Have the child take all of these medicines when sick.

Rescue Medicine: Albuterol/Levalbuterol _____ puffs every 4 hours as needed

Controller Medicine(s):

Continue Green Zone medicines: _____

Add: _____

Change: _____

If the child is in the **yellow** zone more than **24** hours or is getting worse, follow **red** zone and call the doctor right away!

Red Zone If breathing is hard and fast, ribs sticking out, trouble walking, talking, or sleeping.
Get Help Now

Take rescue medicine(s) now

Rescue Medicine: Albuterol/Levalbuterol _____ puffs every _____

Take: _____

If the child is not better right away, call 911
Please call the doctor any time the child is in the red zone.

Asthma Triggers: (List)

School Staff: Follow the Yellow and Red Zone plans for rescue medicines according to asthma symptoms. Unless otherwise noted, the only controllers to be administered in school are those listed as "given in school" in the green zone.

- Both the asthma provider and the parent feel that the child may carry and self-administer their inhalers
 School nurse agrees with student self-administering the inhalers

Asthma Provider Printed Name and Contact Information:

Asthma Provider Signature:

Date:

Parent/Guardian: I give written authorization for the medications listed in the action plan to be administered in school by the nurse or other school members as appropriate. I consent to communication between the prescribing health care provider/clinic, the school nurse, the school medical advisor and school-based health clinic providers necessary for asthma management and administration of this medication.

Parent/guardian signature:

School Nurse Reviewed:

Date:

Date:

Please send a signed copy back to the provider listed above.