

NEW MEXICO ASTHMA ACTION PLAN FOR SCHOOLS

Date _____

School District _____

School Name _____

School Nurse / Health Asst. _____

School Phone # / FAX # _____ / _____

PARENT/GUARDIAN: Please complete the information in the top sections and sign consent at bottom of the page.

Student Name	Date of Birth	Student #	Date of last medical exam:	Inhaler is kept:
*Health Care Provider Name/Title	Provider's Office Phone / FAX #		_____/_____/____	<input type="checkbox"/> with student
Parent/Guardian	Parent's Phone #s			<input type="checkbox"/> Health Office
Emergency Contact	Contact Phone #s			<input type="checkbox"/> Classroom
Allergies to Medications:			Date of last Flu Shot:	Inhaler expires on:
			_____/_____/____	_____/_____/____

Asthma Triggers Identified (Things that make your asthma worse):

Exercise Colds Smoke (tobacco, fires, incense) Pollen Dust Strong Odors Mold/moisture Stress Pests (rodents, cockroaches)

Gastroesophageal reflux Season: Fall, Winter, Spring, Summer Animals Other (food allergies): _____

HEALTH CARE PROVIDER: Please complete Severity Level, Zone Information and Medical Order Below

Asthma Severity: Intermittent or Persistent: Mild Moderate Severe

HEALTHY (Green Zone): You're Doing Well - Take Control Medications EVERYDAY to Prevent Symptoms

<p>You have ALL of these:</p> <ul style="list-style-type: none"> • Breathing is good • No cough or wheeze • Can work and play • Sleep through the night <ul style="list-style-type: none"> • Inhalers work better with spacers • Always use a mask when prescribed 	<p><input type="checkbox"/> No controller medication is prescribed.</p> <p><input type="checkbox"/> _____, _____ puff(s) MDI _____ times a day</p> <p><input type="checkbox"/> _____, _____ nebulizer treatment(s) _____ times a day</p> <p><input type="checkbox"/> _____</p> <p>If exercise triggers your asthma, take:</p> <p>_____, _____ puff(s) MDI _____ minutes before exercise every _____ hours PRN</p>
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CAUTION (Yellow Zone): Slow Down! Continue Green Zone Medicine and ADD:

<p>You have ANY of these:</p> <ul style="list-style-type: none"> • First signs of a cold • Cough or mild wheeze • Exposure to known trigger • Tight Chest • Coughing at night 	<p>DO NOT LEAVE STUDENT ALONE! Call Parent/Guardian when rescue medication is given.</p> <p><input type="checkbox"/> _____, _____ puff(s) every _____ minutes / hours PRN <i>(circle)</i></p> <p>OR</p> <p><input type="checkbox"/> _____, _____ nebulizer treatment(s) & every _____ minutes / hours PRN <i>(circle)</i></p> <p><i>If you are getting worse or not improving after treatment(s) GO TO RED ZONE</i></p>
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EMERGENCY (Red Zone): TAKE THESE MEDICINES NOW AND GET MEDICAL HELP NOW!

<p>Your asthma is getting worse fast:</p> <ul style="list-style-type: none"> • Cannot talk, eat, or walk well • Medicine is not helping • Getting worse, not better • Breathing hard & fast • Getting nervous 	<p>DO NOT LEAVE STUDENT ALONE! Call 911 and start treatment then call Parent/Guardian.</p> <p>Administer: _____, _____ puff(s) every _____ minutes until EMS arrives</p> <p><input type="checkbox"/> For schools that stock Oxygen: (Only use Oxygen if Pulse Oximeter available) Give O2 to keep sat. above 92% unless otherwise contraindicated. Check sat. continually until EMS arrives.</p>
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HEALTH CARE PROVIDER ORDER AND SCHOOL MEDICATION CONSENT

Check all that apply:

____ Student has been instructed in the proper use of his/her asthma medications and **IS ABLE TO CARRY AND SELF-ADMINISTER his/her INHALER AT SCHOOL.**

____ Student is to notify school health personnel after using inhaler at school.

____ Student needs supervision or assistance when using inhaler.

____ Student is unable to carry his/her inhaler while at school.

*SIGNATURE/TITLE: _____ DATE: _____

Parent/Guardian:

I approve of this asthma action plan. I give my permission for the school nurse and trained school personnel to follow this plan, administer medication(s), and contact my provider, if necessary, and share this plan with the SBHC, if applicable. I assume full responsibility for providing the school with the prescribed medications and delivery of monitoring devices. I give my permission for the school to share the above information with school staff that need to know and permission for my child to participate in any asthma educational learning opportunities at school.

SIGNATURE: _____ DATE: _____

SCHOOL NURSE: _____ DATE: _____

Asthma Action Plan for School Student– Parent Instructions

The NM Asthma Action Plan for Schools is designed to help everyone understand the steps necessary for the individual student to achieve the goal of controlled asthma.

- 1. Parents/Guardians:** *Before taking this form to your Health Care Provider, complete the top section with:*
 - Child’s name
 - Child’s doctor’s name & phone number
 - Parent/Guardian’s name
 - Child’s date of birth
 - An Emergency Contact person’s name & phone number
- 2. Your Health Care Provider** will complete the following areas:
 - The asthma severity level of your child’s asthma
 - The effective date of this plan
 - The medicine and dosage information for the Healthy, Caution and Emergency sections
- 3. Parents/Guardians & Health Care Providers together** will discuss and then complete & sign the following areas:
 - Child’s asthma triggers near the top of the form
 - Health care provider order and school medication consent section at the bottom of the form: Discuss your child’s ability to self-administer the inhaled medications, check the appropriate box, and then both you and your Health Care Provider must sign and date the form
- 4. Parents/Guardians:** *After completing the form with your Health Care Provider:*
 - Make copies of the Asthma Action Plan and give the signed original to your child’s school nurse or child care provider
 - Keep a copy easily available at home to help manage your child’s asthma
 - Give copies of the Asthma Action Plan to everyone who provides care for your child, for example: babysitters, before/after school program staff, coaches, scout leaders
 - Call your child’s doctor for control concerns or if rescue medication is used more than 2 times per week for asthma symptoms

For asthma or any medical condition, seek medical advice from your child’s or your health care professional.

FILL OUT THE SECTION BELOW IF YOUR HEALTH CARE PROVIDER CHECKED PERMISSION FOR YOUR CHILD TO SELF-ADMINISTER ASTHMA MEDICATION ON THE FRONT OF THIS FORM.

RECOMMENDATIONS ARE EFFECTIVE FOR ONE (1) SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY

I DO request that my child be ALLOWED to carry the following medication _____ for self-administration in school pursuant to NMAC 6.12.2.9. I give permission for my child to self-administer medication, as prescribed in this NM Asthma Action Plan for Schools for the current school year as I consider him/her to be responsible and capable of transporting, storing and self-administration of the medication. Medication must be kept in its original prescription container. I understand that the school district, agents and its employees shall incur no liability as a result of any condition or injury arising from the self-administration by the student of the medication prescribed on this form. I indemnify and hold harmless the School District, its agents and employees against any claims arising out of self-administration or lack of administration of this medication by the student.

I DO NOT request that my child self-administer his/her asthma medication.

Parent/Guardian Signature

Phone

Date