

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 #
*Health Care Provider Name/Title	Provider's Office Phone / FAX #	
Parent/Guardian	Parent's Phone #s	
Emergency Contact	Contact Phone #s	
Allergies to Medications:		



GREEN means Go!
Use CONTROL medicine daily

YELLOW means Caution!
Add Rescue medicine

RED means EMERGENCY!
Get help from a provider now!

Asthma Triggers Identified (Things that make your asthma worse): <input type="checkbox"/> Exercise <input type="checkbox"/> Colds <input type="checkbox"/> Smoke (tobacco, fires, incense) <input type="checkbox"/> Pollen <input type="checkbox"/> Dust <input type="checkbox"/> Strong Odors <input type="checkbox"/> Mold/moisture <input type="checkbox"/> Stress/Emotions <input type="checkbox"/> Pests (rodents, cockroaches) <input type="checkbox"/> Gastroesophageal reflux <input type="checkbox"/> Season: Fall, Winter, Spring, Summer <input type="checkbox"/> Animals <input type="checkbox"/> Other (food allergies): _____	Date of student's last visit to medical provider: _____ / _____ / _____	Date of Last Flu Shot: _____ / _____ / _____	Inhaler is kept: <input type="checkbox"/> With Student <input type="checkbox"/> In Classroom <input type="checkbox"/> Health Office <input type="checkbox"/> Other _____
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HEALTH CARE PROVIDER: Please complete Severity Level, Zone Information and Medical Order Below

Asthma Severity: Intermittent or Persistent Mild Moderate Severe

Green Zone: Go! Take Control Medications EVERY DAY

You have ALL of these: <ul style="list-style-type: none"> • Breathing is easy • No cough or wheeze • Can work and play • No symptoms at night Peak flow (optional): Greater than \geq _____ (More than 80% of Personal Best)	<input type="checkbox"/> No controller medication is prescribed. <u>Always rinse mouth after using your daily inhaled medication.</u> <input type="checkbox"/> _____ puff(s) MDI with spacer _____ times a day <small>Inhaled corticosteroid or inhaled corticosteroid/long-acting β-agonist</small> <input type="checkbox"/> _____ nebulizer treatment(s) _____ times a day <small>Inhaled corticosteroid</small> <input type="checkbox"/> _____, take _____ by mouth once daily at bedtime <small>Leukotriene antagonist</small> For asthma with exercise, ADD: <input type="checkbox"/> _____ puff(s) MDI with spacer 5 to 15 minutes before exercise For nasal/environmental allergy, ADD: <input type="checkbox"/> _____
Personal best peak flow: _____	

Yellow Zone: Caution! Continue CONTROL Medicine & ADD RESCUE Medicines-

You have ANY of these: <ul style="list-style-type: none"> • Cough or mild wheeze • Tight chest • First signs of a cold • Problems sleeping, Playing or working Peak flow (optional): _____ to _____ (50% - 80% of Personal Best)	DO NOT LEAVE STUDENT ALONE! Call Parent/Guardian when rescue medication is given. <input type="checkbox"/> _____ puff(s) MDI with spacer & every _____ hours as needed <small>Fast-acting inhaled β-agonist</small> OR <input type="checkbox"/> _____ nebulizer treatment(s) & every _____ hours as needed <small>Fast-acting inhaled β-agonist</small> <input type="checkbox"/> Other _____ Call your MEDICAL PROVIDER if you have these signs more than two times a week, or if your rescue medicine does not work! If symptoms are NOT better OR peak flow is NOT improved, go to RED ZONE ↓
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Red Zone: EMERGENCY! Continue CONTROL Medicine & ADD RESCUE Medicines and GET HELP!

You have ANY of these: <ul style="list-style-type: none"> • Cannot talk, eat, or walk well • Medicine is not helping or Getting worse, not better • Breathing hard & fast • Blue lips & fingernails Peak flow (optional): Less than \leq _____ (Less than 50% of Personal Best)	DO NOT LEAVE STUDENT ALONE! → Call for emergency 911 and start treatment <input type="checkbox"/> _____ puff(s) MDI with spacer & every 20 minutes until paramedics arrive <small>Fast-acting inhaled β-agonist</small> OR <input type="checkbox"/> _____ nebulizer treatment(s) every 20 minutes until paramedics arrive <small>Fast-acting inhaled β-agonist</small> Call 911 and start treatment immediately. Then call Parent/Guardian. <input type="checkbox"/> Use only if Oxygen and Pulse Oximeter available: Administer Oxygen _____ l/min for O2 Sat. \leq _____ % and measure O2 Sat. every _____ minutes
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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 designated 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. I assume full responsibility for providing the school with the prescribed medications and delivery and 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: _____