Completed by doctor for Granite City CUSD #9: Date: _____

Illinois Department of Public Health

Asthma Action Plan

Patient Name _____ Weight _____ Date of Birth _____ Peak Flow _____

Symptom Triggers _____ Asthma Severity

Green Zone **"Go! All Clear!"**  • Breathing is easy • Can play, work and sleep without asthma symptoms **Peak Flow Range** (80% - 100% of personal best)	The **GREEN ZONE** means take the following medicine(s) every day. **Controller Medicine(s)** **Dose** _____ _____ _____ Spacer Used _____ **Take the following medicine if needed 10-20 minutes before sports, exercise or any other strenuous activity.** _____
Yellow Zone **"Caution..."**  • Breathing is easy • Cough or wheeze • Chest is tight **Peak Flow Range** (50% - 80% of personal best)	The **YELLOW ZONE** means keep taking your GREEN ZONE controller medicine(s) every day and add the following medicine(s) to help keep the asthma symptoms from getting worse. **Reliever Medicine(s)** **Dose** _____ _____ If beginning cold symptoms, call your doctor before starting oral steroids. _____
Use Quick Reliever (two - four puffs) every 20 minutes for up to one hour or use nebulizer once. If your symptoms are not better or you do not return to the GREEN ZONE after one hour, follow RED ZONE instructions. If you are in the YELLOW ZONE for more than 12-24 hours, call your provider. If your breathing symptoms get worse, call your provider.	
Red Zone **"STOP! Medical Alert!"**  • Medicine is not helping • Nose opens wide to breathe • Breathing is hard and fast • Trouble Walking • Trouble Talking • Ribs show **Peak Flow Range** (Below 50% of personal best)	The **RED ZONE** means start taking your RED ZONE medicine(s) and call your doctor NOW! Take these medicines until you talk with your doctor. If your symptoms do not get better and you can't reach your doctor, go to a **hospital emergency department or call 911 immediately**. **Reliever Medicine(s)** **Dose** _____ _____ _____

For more information on asthma, please visit the National Heart, Lung and Blood Institute at www.nhlbi.nih.gov, the U.S. Centers for Disease Control and Prevention at www.cdc.gov or the U.S. Environmental Protection Agency at www.epa.gov. If you would like more information on Illinois' asthma program, please contact the Illinois Department of Public Health at 217-782-3300.

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☐ This student understands how to use their inhaler and is allowed to carry it to self-administer as needed

Primary Care Provider Signature _____ Date: _____

Primary Care Clinic Name/Stamp: _____ Phone: _____

Students

Exhibit - School Medication Authorization Form

To be completed by the child's parent(s)/guardian(s).

This form is to be used for medication other than medical cannabis. (See 7:270-E2, School Medication Authorization Form - Medical Cannabis.) A new form must be completed every school year for each medication. Keep in the school nurse's office or, in the absence of a school nurse, the Building Principal's office.

Student's Name: _____ Birth Date: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Emergency Phone: _____

School: _____ Grade: _____ Teacher: _____

To be completed by the student's physician, physician assistant with prescriptive authority, or advanced practice RN with prescriptive authority:

Prescriber's Printed Name: _____

Office Address: _____

Office Phone: _____ Emergency Phone: _____

Medication name: _____

Purpose: _____

Dosage: _____ Frequency: _____

Time medication is to be administered or under what circumstances:

_____

_____

Prescription date: _____ Order date: _____ Discontinuation date: _____

Diagnosis requiring medication: _____

Is it necessary for this medication to be administered during the school day? ☐ Yes ☐ No

Expected side effects, if any: _____

Time interval for re-evaluation: _____

Other medications student is receiving: _____

_____

Prescriber's Signature _____ Date _____

For only Parents/Guardians of students requiring asthma inhalers and/or epinephrine injectors:

Is the asthma inhaler and/or epinephrine injector required under a qualifying plan pursuant to 105 ILCS 5/10-22.21b, amended by P.A. 101-205?

☐ Yes ☐ No

Parents/Guardians please attach prescription label (asthma inhaler) and/or written statement (epinephrine injector) here:

For asthma inhalers, attach the prescription label with the name of the asthma medication, the prescribed dosage, and the time at which or circumstances under which the asthma medication is to be administered. 105 ILCS 5/22-30(b)(2)(i).

For an epinephrine injector, attach a written statement from the student's physician, physician assistant, or advanced practice registered nurse containing the name and purpose of the epinephrine, injector; the prescribed dosage; and the time or times at which or the special circumstances that the epinephrine injector should be administered. 105 ILCS 5/22-30(b)(2)(ii)(A)-(C).

For only parents/guardians of students who need to self-administer medication required under a qualifying plan:

I grant permission for my child to self-administer his or her medication required under an asthma action plan, an Individual Health Care Action Plan, an Illinois Food Allergy Emergency Action and Treatment Authorization Form, a plan pursuant to Section 504 of the federal Rehabilitation Act of 1973, or a plan pursuant to the federal Individuals with Disabilities Education Act. 105 ILCS 5/10-22.21b, amended by P.A. 101-205.

Medication(s) other than asthma inhalers and/or epinephrine injectors (complete section above) required under a qualifying plan that student is permitted to self-administer:

Prescription date: _____ Order date: _____ Discontinuation date: _____

Diagnosis requiring medication: _____

Is it necessary for this medication to be administered during the school day? ☐ Yes ☐ No

Expected side effects, if any: _____

Time interval for re-evaluation: _____

Other medications student is receiving: _____

_____ _____

Prescriber's Signature Date

If the medication is an asthma inhaler or epinephrine injector, be also sure to complete the section above and attach the required label and/or written statement as required above.

Please initial to indicate (1) receipt of this information, and (2) authorization for your child to self-administer medication under a qualifying plan.

_____

Parent/Guardian Initials

For only parents/guardians of students who need to carry and use their asthma medication or an epinephrine injector:

I authorize the School District and its employees and agents, to allow my child to self-carry and self-administer his or her asthma medication and/or epinephrine injector: (1) while in school, (2) while at a school-sponsored activity, (3) while under the supervision of school personnel, or (4) before or after normal school activities, such as while in before-school or after-school care on school-operated property. Illinois law requires the School District to inform parents/guardians that it, and its employees and agents, incur no liability, except for willful and wanton conduct, as a result of any injury arising from a student's self-carry and self-administration of asthma medication or epinephrine injector. 105 ILCS 5/22-30, amended by P.A 102-413.

Please initial to indicate (1) receipt of this information, and (2) authorization for your child to carry and use his or her asthma medication or epinephrine injector.

_____

Parent/Guardian Initials

For all parents/guardians:

By signing below, I agree that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize the School District and its employees and agents, on my behalf, to administer or to attempt to administer to my child (or to allow my child to *self-administer* pursuant to State law, while under the supervision of the employees and agents of the School District), lawfully prescribed medication in the manner described above. This includes administration of undesignated epinephrine injectors, opioid antagonists, or asthma medication, to the extent the School District maintains such undesignated supplies, to my child when there is a good faith belief that my child is having an anaphylactic reaction, opioid overdose, or asthma episode, whether such reactions are known to me or not, and if applicable, undesignated glucagon when authorized by my child's diabetes care plan and if my child's glucagon is not available on-site of has expired. 105 ILCS 5/22-30, amended by P.A 102-413.; 105 ILCS 145/27, added by P.A. 101-428. **I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse and specifically consent to such practices**, and

I agree to indemnify and hold harmless the School District and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration or the child's self-administration of medication.

Parent/Guardian Printed Name _____

Address (if different from Student's above): _____

Home Phone: _____ Cell Phone: _____ Emergency Phone: _____

_____ _____

Parent/Guardian Signature Date

Adopted:

Revised: 11/13/2006, 01/11/2012, 01/27/2015, 09/11/2018, 01/08/2019, 01/14/2020, 06/28/2022