HIGLEY UNIFIED SCHOOL DISTRICT ASTHMA ACTION PLAN

Child Name:_____ Birthdate:_____

Parent/Guardian Name:_____ Phone:_____

Healthcare Provider Name:_____ Phone:_____

Triggers: ☐ Strong odors or fumes ☐ Exercise ☐ Dust ☐ Animals ☐ Illness ☐ Molds ☐Pollen

☐Emotions/Stress ☐ Other: _____

Life Threatening Allergy: _____

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child, and if necessary, contact our healthcare provider. I assume full responsibility for providing the school/program prescribed medication and supplies, and to comply with board policies, if applicable. I am aware 911 may be called if a quick relief inhaler is not at school and my child is experiencing symptoms. I approve this care plan for my child.

PARENT SIGNATURE	DATE	HUSD Health Aide	DATE

HEALTHCARE PROVIDER COMPLETE ALL ITEMS, SIGN AND DATE:	QUICK RELIEF (RESCUE) MEDICATION: ☐Albuterol ☐Other: _____ Common side effects: heart rate, tremor ☐Have child use spacer with inhaler. Asthma Severity: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent Controller medication used at home: _____

	IF YOU SEE THIS:	**DO THIS:**
GREEN ZONE: No Symptoms Pretreat	• No current symptoms • Doing usual activities • O_2 Sat. %< _____	Pretreat strenuous activity: ☐Not required ☐Routine ☐Student/Parent request Give QUICK RELIEF MED 10-15 minutes before activity: ☐2 puffs ☐4 puffs Repeat in 4 hours, if needed for additional physical activity. ***If child is currently experiencing symptoms, follow YELLOW ZONE.***
YELLOW ZONE: Mild symptoms	• Trouble breathing • Wheezing • Frequent cough • Complains of tight chest • Not able to do activities, but talking in complete sentences • O_2 Sat %< _____	1. Stop physical activity. 2. Rule out if student has anaphylaxis. If anaphylactic signs/ symptoms, follow anaphylaxis care plan. 3. Give QUICK RELIEF MED: ☐2 puffs ☐4 puffs 4. Stay with Student and maintain sitting position. 5. **REPEAT** QUICK RELIEF MED, if not improving in 15 minutes: ☐2 puffs ☐4 puffs 6. Student may go back to normal activities, once symptoms are relieved. 7. Notify parents/guardians ***If symptoms do not improve or worsen, follow RED ZONE.***
RED ZONE: EMERGENCY Severe Symptoms	• Coughs constantly • Struggles to breathe • Trouble talking (only speaks 3-5 words) • Skin of chest and/or neck pull in with breathing • Lips/fingernails gray or blue • Level of consciousness • O_2 Sat. %< _____	1. Give QUICK RELIEF MED: ☐2 puffs ☐4 puffs Refer to anaphylaxis plan, if student has life-threatening allergy. 2. Call 911 and inform EMS the reason for the call. 3. Stay with student. Remain calm, encouraging slower, deeper breaths. 4. Notify parents/guardians. 5. If symptoms do not improve, **REPEAT** QUICK RELIEF MED: ☐2 puffs ☐4 puffs every 5 minutes until EMS arrives.

PROVIDER INSTRUCTIONS FOR QUICK RELIEF INHALER USE: CHECK APPROPRIATE BOX(ES)

I have instructed _____ in the proper ways to use their medication.

☐ Student needs assistance to use their inhaler.

☐ Under supervision in the health office, the student does not require assistance to use their inhaler.

HEALTH CARE PROVIDER SIGNATURE	PRINT PROVIDER NAME	DATE	FAX	PHONE

STUDENT ASTHMA CARE PLAN

*This section is to be filled out by Parent/Guardian

Name: _____ Grade: _____ Age: _____

Homeroom Teacher/Room: _____

Parent/Guardian Name: _____ Phone: _____

Parent/Guardian Name: _____ Phone: _____

Emergency Contact: Name_____ Relationship _____ Phone_____

Emergency Contact: Name_____ Relationship _____Phone_____

Physician Treating Student for Asthma: _____ Phone: _____

Identify the triggers which start an asthma episode (Check all the apply to the student)

☐ Animals ☐ Weather ☐ Change in temperature ☐ Illness ☐ Dust ☐ Molds ☐Pollen ☐Emotions/Stress
☐ Respiratory infections ☐ Strong odors or fumes ☐ Exercise ☐ Smoke ☐Food: _____

☐ Other: _____

Comments: _____

Control of School Environment

(List any environmental control measures, pre-medications and/or dietary restrictions that the student needs to prevent an asthma episode.) _____

_____

Steps to take during an asthma episode:

1. Perform Visual Assessment
    a. Skin color
    b. How does student look
    c. Body position
2. Subjective Information from student
    a. How they feel
    b. Have they used a rescue inhaler (if they are self-carry)
    c. PE, sick, history of asthma or respiratory concerns
3. Objective Information from student
    a. Check O2 Level with pulse oximeter
    b. Pulse
    c. Breathing Pattern
4. **<u>Follow Student Asthma Action Plan</u>**
5. Contact parent/guardian if _____
6. Immediately seek emergency medical care if the student has any of the following:

✓ Does not respond to Quick Relief/Rescue Medication
✓ Gasping for breath; struggling to breath; hunched over
✓ Lips and/or fingernails are blue or gray
✓ Skin of chest and/or neck pull in with breathing
✓ Decreased level of consciousness
✓ Trouble walking or talking

STUDENT ASTHMA CARE PLAN

Emergency Asthma Medications

Name_____ Amount_____ When to Use _____

Name_____ Amount_____ When to Use _____

Name_____ Amount_____ When to Use _____

Daily Asthma Medication

Name_____ Amount_____ When to Use _____

Name_____ Amount_____ When to Use _____

Comments/Special Instruction

_____

_____

ALL Medications

☐ I have instructed _____in the proper way to use his/her medications.

Physicians Signature:_____Date:_____

Parent/Guardian Signature_____Date:_____

STUDENT ASTHMA CARE PLAN

Asthma Bus Plan

Student Name: _____ Teacher: _____ Year: _____

Route: _____ Grade: _____ Age: _____

Homeroom Teacher/Room: _____

Parent/Guardian Name: _____ Phone: _____

Parent/Guardian Name: _____ Phone: _____

Emergency Contact: Name_____ Relationship _____ Phone_____

Emergency Contact: Name_____ Relationship _____Phone_____

Physician Treating Student for Asthma: _____ Phone: _____

- If student is having difficulty breathing, shortness of breath, chest tightness, coughing
- Allow student to rest, assist student to remain calm, notify parent
- Allow student to self-administer inhaler if available, per provider's instructions; assist student to administer medication if they are unable to, or need help
- Call 911 if student continues to have difficulty breathing, skin is pale, lips and fingernails appear gray/blue, nostrils are flaring, student is struggling to breathe, etc., when in doubt call 911!
- For any severe distress, call 911

Notify Parent for:

_____

_____

_____

Parent/Guardian Signature_____Date:_____

Nurse/Health Aide Signature _____Date:_____

Direction for Inhaler Use:

- Remove cap
- Shake inhaler
- Keep away from eyes
- Hold mouthpiece 1 ½ -2 inches in front of mouth
- Gently breathe out
- Press inhaler and take a slow breath (hold for 5 – 10 seconds)

HEALTH AIDE: EMAIL THIS FORM TO HUSD TRANSPORTATION