

ASTHMA ACTION PLAN

Name: _____ D.O.B. _____ Teacher _____
 School Nurse: _____ Phone Number: _____
 Health Care Provider Treating Student for Asthma: _____ Ph: _____
 Preferred Hospital _____
 My Personal Best Peak Flow Reading: _____ (If Applicable)

ID Photo

Green Zone: All Clear

- Breathing is easy. No asthma symptoms with activity or rest
- Peak Flow Range: _____ to _____ (80 to 100% of personal best) *If applicable.*
- Pre-medicate if needed 10 to 20 minutes before sports, exercise or other strenuous activity.**
- Pre-exercise medications listed in #1 below.**

Yellow Zone: Caution

- Cough or wheeze. Chest is tight. Short of breath.
- Peak Flow Range: _____ to _____ (50 to 80% of personal best) *If applicable.*
- Medicate with quick reliever. Give medications as listed below.
- May re-check peak flow in 15 to 20 minutes.
- Student should respond to treatment in 15-20 minutes and return to green zone, if not contact parent.

Red Zone: Emergency Plan

- Call EMS if student has any of the following:
 - ✓ Coughs constantly
 - ✓ No improvement 15-20 minutes after initial treatment with medication
 - ✓ Hard time breathing with some or all of these symptoms of respiratory distress:
 - Chest and neck pulled in with breathing
 - Stooped body posture
 - Struggling or gasping
 - ✓ Trouble with walking or talking due to shortness of breath
 - ✓ Lips or fingernails are grey or blue
 - ✓ Peak flow below: _____. (50% of personal best) *If applicable.*
- Medicate with quick reliever. Give medications as listed below.
- Re-check peak flow in 15 to 20 minutes.
- Student should respond to treatment in 15-20 minutes.
- Contact parent/guardian.

Emergency Asthma Medications - to be completed by Health Care Provider

	Name	Amount
1.	_____	_____
2.	_____	_____

Health Care Provider AUTHORIZATION:

- This child has received instruction in the proper use of his/her asthma medications.
- It is my professional opinion that this student *should/should not* (Circle one) be allowed to carry, store and use his/her asthma medications by him/herself.

Health Care Provider Signature: _____ **Date:** _____

Side 2 to be filled out by Parent/Guardian, Student, and School

Side 2: To Be Completed by Parent/Guardian and StudentSTUDENT ASTHMA ACTION CARD (*continued*) Student Name: _____ D.O. B. _____**DAILY ASTHMA MANAGEMENT PLAN**

• **Identify the things which start an asthma episode (If known, check each that applies to the student. These should be excluded in the student's environment as much as possible.)**

- | | | |
|---|---|--------------------------------------|
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Chalk dust/dust | <input type="checkbox"/> Food _____ |
| <input type="checkbox"/> Strong odors or fumes | <input type="checkbox"/> Carpets in the room | <input type="checkbox"/> Molds |
| <input type="checkbox"/> Respiratory infections | <input type="checkbox"/> Animals _____ | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Change in temperature | <input type="checkbox"/> Pollens (Spring/Summer/Fall) | <input type="checkbox"/> Other _____ |

• **List all asthma medications taken each day.**

	Name	Amount	When to Use
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

COMMENTS / SPECIAL INSTRUCTIONS

AUTHORIZATIONS**Parent/Guardian:**

- I want this plan to be implemented for my child in school.
- I authorize my child to carry and self-administer asthma medications and I agree to release the school district and school personnel from all claims of liability if my child suffers any adverse reactions from self-administration and/or storage of asthma medications. **Yes** **No**
- It is recommended that backup medication be stored with the school/ school nurse in case a student forgets or loses inhaler or inhaler is empty. The school district is not responsible or liable if backup medication is not provided to the school/ school nurse and student is without working medication when medication is needed.

Your signature gives permission for the nurse to contact and receive additional information from your health care provider regarding the asthma condition and the prescribed medication.

Parent/Guardian Signature: _____ **Date:** _____

Student Agreement:

- I understand the signs and symptoms of asthma and when I need to use my asthma medication.
- I agree to carry my medication with me at all times.
- I will not share my or use my asthma medications for any other use than what it is prescribed for.

Student Signature: _____ **Date:** _____

Approved by School Nurse/School Principal Back-up medication is stored at school Yes No

School Nurse/Principal Signature: _____ **Date:** _____