ASTHMA ACTION PLAN

to be completed by Health Care Provider

Name: _____D.O.B. _____ Teacher _____

School Nurse: _____ Phone Number: _____ **Fax**_____

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 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 (911) immediately 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*** 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 Student

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.)

☐ Exercise	☐ Carpets in the room	☐ Latex
☐ Strong odors or fumes	☐ Animals _____	☐ Other _____
☐ Respiratory infections	☐ Pollens (Spring/Summer/Fall)	
☐ Change in temperature	☐ Food _____	
☐ Chalk dust/dust	☐ Molds	

· List <u>all</u> asthma medications taken each day.

Name	Amount	When to Use
1.		
2.		
3.		

COMMENTS / SPECIAL INSTRUCTIONS

_____

_____

_____

AUTHORIZATIONS

Parent/Guardian:

☐ I request this plan to be implemented for my child in school and I will provide the medications as ordered

☐ I understand that in the absence of the school nurse, other trained school personnel may administer the medication

☐ I will notify the school immediately if the medication is changed

☐ <u>If authorized by the HCP</u>, I authorize my child to carry and self-administer asthma medications

☐ I agree to defend and hold harmless 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.

☐ I understand that it is recommended that backup medication be stored with the school/school nurse in case my student forgets or loses their inhaler or the 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.

☐ I understand that the parent is responsible for emergency asthma medications for any before and after school activities separate from the school day supply.

<u>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.</u>

Parent/Guardian Signature: _____ Date: _____

Student Agreement: required for authorized self-carry of Asthma medication

☐ I have been trained in the use of my inhaler and 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 notify a responsible adult (Teacher, Nurse, coach, noon duty, etc.) IMMEDIATELY when my inhaler is used.

☐ I will not share or use my asthma medications for any other use than what it is prescribed for.

☐ I will not leave my inhaler unattended while at school or on school sponsored events.

Student Signature: _____ Date: _____

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

School Nurse/Principal Signature: _____ Date: _____