

Student Name _____
School/Teacher _____

Date of Birth: _____

FSD ASTHMA ACTION PLAN

PARENT/GUARDIAN TO COMPLETE THE SECTION BELOW

Student Name: _____
Father's Name: _____ Home Phone: _____
Cell Phone: _____ Work Phone: _____
Mother's Name: _____ Home Phone: _____
Cell Phone: _____ Work Phone: _____
Emergency Contact if parent not available: _____
(Authorized to act in behalf of parents if we are unable to contact parent)
Home Phone: _____ Cell: _____ Work Phone: _____
Physician Name: _____ Phone: _____ Fax: _____

Please describe brief history of previous episodes of asthma. Describe frequency of episodes, symptoms and treatment that was required for the reaction(s).

Please list all current medications taken at home:

Name of Medication	Dosage and Strength	Purpose	Days Given	Time
ASTHMA INHALERS AND NEBULIZER MEDICATIONS FOR QUICK RELIEF OF ASTHMA SYMPTOMS ARE TO BE PROVIDED BY THE PARENT/GUARDIAN TO BE KEPT AT SCHOOL AND AVAILABLE FOR THE STUDENT DURING SCHOOL AND ON FIELD TRIPS. STUDENTS WHO ARE COMPETENT TO SELF ADMINISTER (SEE PHYSICIAN ORDERS) MAY CARRY THEIR INHALER AT PARENT REQUEST.				

IN THE EVENT THAT ASTHMA MEDICATIONS ARE NEEDED AND ARE NOT AVAILABLE, 911 WILL BE CALLED.

EXPIRED MEDICATIONS MUST BE REPLACED. EXPIRED MEDICATIONS CANNOT BE ADMINISTERED BY THE SCHOOL NURSE OR OTHER TRAINED ASSISTIVE PERSONNEL.

ALL MEDICATIONS SHOULD BE PICKED UP BY A PARENT/GUARDIAN AT THE END OF THE SCHOOL YEAR. MEDICATIONS WHICH ARE NOT PICKED UP WILL BE DISCARDED ACCORDING TO STATE REGULATIONS.

.....
I understand that health information regarding my child will be kept confidential, but shared with school staff on a need to know basis in order to protect the health and safety of my child during the school day.

I understand that my child is competent to self-administer his/her medications with assistance from the school nurse or other designated, trained employee. I release the Franklin Special District from any legal claim and assume full responsibility for any adverse reactions my child may suffer as a result of taking or failing to take the medication. I understand my child will be administered medications and emergency treatment as indicated by the physician orders on the other side of this form. This treatment will be administered even if a parent/guardian cannot be reached. The physician providing medication orders on the other side of this form has my permission to provide this and other information regarding my child's health to the school nurse, principal or designated assistive personnel. The school nurse has my permission to speak with my child's physician regarding this plan and related health issues.

I understand and agree that my child may be assisted with medication administration/procedures on field trips or in the absence of a school nurse by unlicensed trained personnel (such as a teacher). I understand that if emergency medications have not been provided by the parent/guardian, 911 will be called.

Parent/Guardian Name

Parent/Guardian Signature

Date

Nurse Name

Nurse Signature

Date

Student Name _____
School/Teacher _____

Date of Birth: _____

Franklin Special District Asthma Action Plan/Medication Order

SECTION BELOW TO BE COMPLETED BY STUDENT'S PHYSICIAN

TRIGGERS: (Check those which apply to this student)

____ Exercise	____ Pollens/Seasonal Allergies	____ Cold Air/Weather changes
____ Respiratory Illness	____ Cigarette Smoke	____ Animal dander: type: _____
____ Emotional Stress	____ Dust, Dust Mites	____ Other: (Specify) _____

GREEN ZONE: **DOING WELL:** No cough, wheeze, chest tightness or shortness of breath and can do normal activities. **Continue home medications for long-term control.**

YELLOW ZONE: **ASTHMA IS GETTING WORSE:** Symptoms include cough, wheeze, chest tightness, shortness of breath, can do some, but not all, usual activities, waking at night due to asthma symptoms. **Add quick relief medications as ordered below.**

RED ZONE: **GET HELP IMMEDIATELY! CALL 911** if student has not responded to quick-relief medications and has trouble walking or talking due to shortness of breath, the lips or fingernails are gray or blue, the skin is sucked in around neck and ribs during breathing or the child does not respond normally. Notify parent and physician.

QUICK RELIEF MEDICATION ORDERS

Inhaler Medication: _____ **Dosage:** ____ puffs every ____ hours p.r.n. per inhalation.

____ **Repeat dose if needed** in ____ minutes. If symptoms persist and do not return to GREEN ZONE, contact parent to seek additional medical care or proceed to RED ZONE orders if indicated by symptoms.

____ **Asthma is exercise induced.** In addition to above p.r.n. doses, give ____ puffs ____ minutes prior to physical activity/gym.

Possible side effects of medication: _____

Quantity Provided/Received: _____ Medication Expiration Date: _____

Medication received by _____ Date _____

OR

Nebulizer Medication: _____ **Dosage:** _____ every ____ hours p.r.n. per nebulizer.

____ **Repeat dose if needed** in ____ minutes. . If symptoms persist and do not return to GREEN ZONE, contact parent to seek additional medical care or proceed to RED ZONE orders if indicated by symptoms.

Possible side effects: _____

Quantity Provided/Received _____ Medication Expiration Date: _____

Medication received by _____ Date _____

ADDITIONAL ORDERS FOR INHALED MEDICATIONS

____ It is my professional opinion that this student is competent to **self-administer** his/her inhaled medication and should be allowed to carry his/her inhaler. Each dose is to be documented by the student or teacher and the documentation supplied to the school nurse on at least a weekly basis.

____ It is my professional opinion that this student **receive assistance** with administration of inhaled medication by the school nurse or other designated, trained employee.

____ Notify physician if rescue medication use exceeds ____ times/week as this may indicate poorly controlled asthma.

____ Additional Orders (Specify): _____

PHYSICIAN NAME: _____ **PHONE:** _____

PHYSICIAN ADDRESS: _____ **FAX:** _____

PHYSICIAN SIGNATURE: _____ **DATE:** _____