



Great Falls Public Schools – Asthma Action Plan

Student Name:	ID:	School:	Grade:	Teacher:
DOB:	Plan Year:	School Nurse:	Phone#:	
Does the student have any of the following plan(s)? 504 Y/N IEP Y/N		Does the student ride the school bus? Y/N		
Parent/Guardian:		Phone #:		
Emergency Contact:		Phone #:		
Primary Provider:		Specialist:		
Drug Allergies:		Daily Medications:		

Location of inhaler:	Self Carry: Y/N	Asthma Severity: Mild ☐ Moderate ☐ Severe ☐
Triggers: ☐ Colds/Illness ☐ Smoke ☐ Exercise ☐ Animals ☐ Strong odors ☐ Mold/Moisture ☐ Pollen ☐ Pests/Rodents ☐ Dust Seasonal: ☐ Fall ☐ Winter ☐ Spring ☐ Summer		
Student's asthma symptoms: ☐ Chest Pain ☐ Shortness of Breath ☐ Coughing ☐ Wheezing ☐ Other _____		

Green Zone: Doing Well Breathing is good – No cough or wheeze – Can work and play – Sleep well at night

Always use a spacer with inhalers as directed.

Controller Medicine(s): _____

Controller Medicine(s) Given in School: _____

Rescue Medicine: Albuterol/Levalbuterol _____ puffs every four hours as needed

Exercise Medicine: Albuterol/Levalbuterol _____ puffs 15 minutes before activity as needed

Yellow Zone- CAUTION Some problems breathing – Cough, wheeze, or tight chest – Problems working or playing – Wake at night

Rescue Medicine: Albuterol/Levalbuterol _____ puffs every 4 hours as needed

Controller Medicine(s): _____

☐ Continue Green Zone medicines: _____

☐ Add: _____

☐ Change: _____

If the child is in the yellow zone for more than 24 hours or is getting worse, follow the red zone and call the doctor right away!

Red Zone- GET HELP NOW If breathing is hard and fast, ribs sticking out, trouble walking, talking, or sleeping.

Take rescue medicine(s) now

Rescue Medicine: Albuterol/Levalbuterol _____ puffs every _____

Take: _____

If the child is not better right away, call 911-Please call the doctor any time the child is in the red zone.

PERMISSION FOR STUDENT TO SELF ADMINISTER

Healthcare provider confirms that student has been instructed in proper use of the medication(s) listed above and is able to self-administer without school personnel supervision.
(If marked parent needs to sign authorization on page 2)

☐ Both the asthma provider and the parent feel that the child may carry and self-administer their inhalers

☐ School nurse agrees with student self-administering the inhalers

Primary Physician:	Date:	Building Administrator:	Date:
Parent:	Date:	School Nurse:	Date:

For Students who carry and/or self-administer medications:

Authorization by parent/guardian: See generally Mont. Code Ann 20-5-420.

As the parent/guardian of the student named in this plan, I confirm this student has been instructed by his/her health care provider on the proper use of this/these medication(s). He/she demonstrated to me he/she is physically, mentally, and behaviorally capable to assume this responsibility. He/she has my permission to self-medicate as listed above, if needed. If he/she has used epinephrine during school hours, he/she understands the need to alert the school nurse or other adult at the school who will provide follow-up care, including making a 9-1-1 emergency call.

- I acknowledge the school district or nonpublic school and its employees and agents are not liable as a result of any injury arising from the self-administration of medication by the student, and I indemnify and hold them harmless for such injury, unless the claim is based on an act or omission that is the result of gross negligence, willful and wanton conduct, or an intentional tort.
- I agree to work with the school in establishing a plan for use and storage of backup medication. This will include a predetermined location to keep backup medication to which the student has access in the event of an asthma, severe allergy, or anaphylaxis emergency. I have provided the following backup medication: _____
- I understand in the event the medication dosage is altered, a new "self-administration form" must be completed, or the health care provider may rewrite the order on his/her prescription pad and I, the parent/caretaker relative/guardian, will sign the new form and assure the new order is attached.
- I understand it is my responsibility to pick up any unused medication at the end of the school year, and any medication not picked up will be disposed of.
- I authorize the school administration to release this information to appropriate school personnel and classroom teachers.

Parent/Guardian signature: _____ Date: _____

Illustration by Javier Trigo

