



Neenah Joint School District
410 S Commercial St.
Neenah, WI 54956

Picture

Asthma Management and Emergency Plan

Student _____ Date _____ Grade _____

Date of Birth _____ School _____ Teacher _____

Address _____ City _____ Zip Code _____

Emergency Contacts:

Name _____ Number _____ Relationship _____

Name _____ Number _____ Relationship _____

Name _____ Number _____ Relationship _____

☐ Self carry & Self administer medication
administration

☐ Needs supervision and/or assistance with

Asthma Triggers (list): _____

Asthma Severity: ☐ Intermittent ☐ Mild Persistent ☐ Many or Severe Asthma attacks/exacerbations

😊 Green Zone Have the student take these medications everyday, even when the student feels well.

Always use a spacer with inhalers as directed.

Exercise Pretreatment Medication and/or Daily medication:

Type: _____ Dose: _____ (Puffs) Frequency: _____ Expiration Date: _____

😞 Yellow Zone Begin the sick treatment plan if the student has a cough, wheeze, shortness of breath, or tight chest.

Stop Physical Activity!

Rescue Medication:

Type: _____ Dose: _____ (Puffs) Frequency: _____ Expiration Date: _____

Call parent/guardian and school nurse. If symptoms worsen, follow the red zone!

😞 Red Zone If breathing is hard and fast, ribs sticking out, trouble walking/ talking, turning blue. GET HELP NOW!

Take Rescue Medication Now:

Type: _____ Dose: _____ (Puffs) Frequency: _____ Expiration Date: _____

Call 911 and encourage the student to take slow, deep breaths.

Call parent/guardian and school nurse

-OVER-

If symptoms continue, repeat rescue medication as above OR _____

Student Name: _____ **Student DOB:** _____

Additional comments or information related to students Asthma:

Parent consent for management of health condition while at school or other school related activities:

I, the parent/guardian of the above named student, request that this action plan be used to guide the care of my child in case of a health care emergency. I agree to:

- Provide the necessary supplies and equipment.
- Notify the school staff or school district nurse of any changes in the student's health status.
- Notify the school staff and complete new consent for changes in orders from the student's health care provider.
- Authorize the school nurse to communicate with my child's primary care physician or specialist regarding my child's health condition as needed.
- School staff interacting directly with my child may be informed about this health care plan.
- Submit new forms annually if the health condition still exists or inform the school that the condition no longer exists.

Parent/Guardian Signature _____ **Date** _____

Physician Information

Print Name of Provider _____ Clinic Name _____

Phone Number _____ Fax Number _____

Address _____

Signature of Provider _____ Date _____

Provider NPI # _____

By signing this form you are acknowledging this medication/Health plan is medically necessary for school