American Lung Association.

My Asthma **Action Plan**
For Home and School

Scan the QR Code to access How-To Videos

Name: _____ School: _____ DOB: ____ / ____ / _____

Severity Classification: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Asthma Triggers (list): _____

Date Completed: ____ / ____ / _____ **Vaccinations updated:** ☐ Yes ☐ No

Green Zone: Doing Well

Symptoms: Breathing is good – No cough or wheeze – Can work and play – Sleep well at night

	Medicine	How much to take	When and how often to take it	Take at
Control Medicine(s)				☐ Home ☐ School
Quick Relief Medicine(s)				☐ Home ☐ School
SMART/ MART	☐ ICS/Formoterol _____	___ puff(s) with spacer	_____	
	(daily max dose 12 puffs for ages 12+ yrs & 8 puffs for ages 4-11 yrs)			
Exercise Induced	☐ Use quick-relief medicine 10 minutes before physical activity as instructed			

Yellow Zone: Caution

Symptoms: Some problems breathing – Cough, wheeze, or tight chest – Problems working or playing – Wake at night

	Medicine	How much to take	When and how often to take it
Quick-relief Medicine(s)	☐ _____	_____	_____ *every 20 minutes for up to 1 hour OR Nebulizer (use once)*
Control Medicine(s)	☐ Continue Green Zone medicines		
SMART as quick reliever	☐ ICS/Formoterol _____	___ puff(s) with spacer	_____
	(daily max dose 12 puffs for ages 12+ yrs & 8 puffs for ages 4-11 yrs)		
Other	☐ _____	_____	_____

You should feel better within 20–60 minutes of the quick-relief treatment. If you are getting worse THEN follow the instructions in the RED ZONE and call your doctor or 911 right away!

Red Zone: Get Help Now!

Symptoms: Lots of problems breathing – Cannot work or play – Getting worse instead of better – Medicine is not helping – I feel very sick

Take Quick-relief Medicine NOW!

	Medicine	How much to take	When and how often to take it
	☐ _____	___ (puffs)	_____
SMART as quick reliever	☐ ICS/Formoterol _____	___ puff(s) with spacer	_____
Other	☐ _____	_____	_____

Call 911 immediately if the following danger signs are present:

- Trouble walking/talking due to shortness of breath
- Lips or fingernails are blue
- Still in the red zone after 15 minutes

Parent/Guardian

☐ I give permission for the medicines listed in the action plan to be administered in school by the nurse or designated trained staff.

☐ I consent to communication between the prescribing health care provider or clinic, the school nurse, the school medical advisor or school-based health clinic providers necessary for asthma management and administration of this medicine.

Name _____ Date _____ Phone (____) ____ - _____ Signature _____

Healthcare Provider

Name _____ Date _____ Phone (____) ____ - _____ Signature _____

School Nurse

☐ The student has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

Name _____ Date _____ Phone (____) ____ - _____ Signature _____

Please provide a signed copy to the parent, school nurse and healthcare provider.

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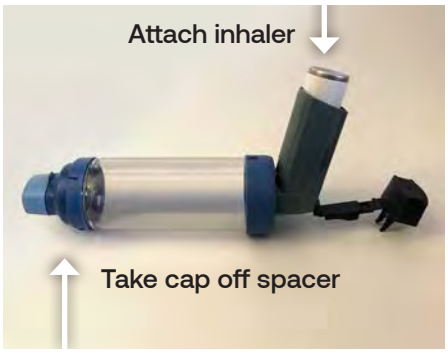
How to Use Your Inhaler and Spacer



1. Take the cap off the inhaler



2. Shake the inhaler for 5 seconds



3. Attach to spacer and take cap off spacer



4. Breathe **OUT** all the way



5. Close lips around mouthpiece



6. Press down here



7. Breathe in **SLOWLY, DEEPLY**



8. Hold your breath for 10 seconds if you can. Then breathe out slowly.



If you need another puff of medicine, wait 1 minute then repeat steps 5-9.



9. Rinse with water and **SPIT OUT**

For more asthma videos, handouts, tutorials and resources, visit **Lung.org/asthma**.

You can also connect with a respiratory therapist for one-onone, free support the American Lung Association's Lung HelpLine at **1-800-LUNGUSA**.

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KINGSWAY REGIONAL SCHOOL DISTRICT

Committed to Excellence

Mrs. Megan Anastasia, RN, BSN, CSN
7th & 8th, ext. 3022

Mrs. Kate Richards, RN, BSN, CPN, CSN
9th & 10th, ext. 4221

Mrs. Barbara Neal, RN, BSN, CSN
11th & 12th, ext. 4216

Middle School Fax (856) 467-5968

High School Fax (856) 467-4136

Request for Administration of Medication at School

Date: _____ Grade: _____

Student's Name: _____ Date of Birth/Age: _____

1. Diagnosis: _____
2. Student may attend school while on the medication: YES _____ NO _____
3. Name of medication: _____
4. Dosage and time of administration during school day: _____
5. Length of time medication to be administered at school: _____
6. May be excused from school-time dose on field trip or half day: YES _____ NO _____

Physician's Signature: _____

Physician's Phone Number: _____

Address/Office Stamp:

Dear Parent/Guardian,

Pease sign to indicate approval for the school nurse to administer this medication to your child as ordered. Your signature also gives the ordering clinician permission to share, discuss, and release the order with the school nurse.

Date: _____ Parent/Guardian signature: _____

Please note: Medication must be brought to school in its original container by parent/guardian. Orders are valid only for the current school year.

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Indemnification/Hold Harmless Agreement for Pupil Self-Administration of Medication

We, the parents/guardians of _____
(Pupil Name)

hereby acknowledge and agree that the Kingsway Regional High School District shall incur no liability as a result of any injury arising from the self-administration of medication by

_____.
(Pupil Name)

We further agree that, pursuant of N.J.S.A. 18A:40-12.3(d), we shall indemnify, hold harmless and defend the Kingsway Regional High School District, its employees and agents, from and against any and all costs, expenses (including reasonable counsel fees), liabilities, judgements, losses, damages, suits, actions, fines, penalties, claims or demands of any kind and asserted by or on behalf of any person or entity arising out of or in any way connected with the self-administration of medication by _____.
(Pupil Name)

_____ _____
Parent/Guardian Signature Date