

School Asthma Action Plan

Name	Birth Date
Emergency Contact	Phone Cell
Triggers <input type="checkbox"/> Mold/Pollens <input type="checkbox"/> Animals <input type="checkbox"/> Colds <input type="checkbox"/> Dust <input type="checkbox"/> Exercise <input type="checkbox"/> Smoke <input type="checkbox"/> Weather <input type="checkbox"/> Fragrance	

Green Zone: Doing Well	• Breathing is good • No cough or wheeze • Can work and play • Sleeps all night • No early warning signs • Peak Flow Meter if used: 80-100% of personal best _____
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School Action: Follow actions in marked boxes below for exercise induced asthma

<input type="checkbox"/> Medication Before Exercise <input type="checkbox"/> Medication Before Recess <input type="checkbox"/> Use routinely every _____ hours Medication with spacer: <input type="checkbox"/> Albuterol <input type="checkbox"/> Ventolin <input type="checkbox"/> Proventil <input type="checkbox"/> Xopenex Medication without spacer: <input type="checkbox"/> Maxair Autohaler Dose: _____ puffs When: 10-15 minutes before listed activity Start Date: School Year Stop Date: School Year

Yellow Zone: Getting Worse (mild trouble breathing)	• Cough, wheeze, chest tight • Problems working/ playing • Early warning signs • Shortness of breath • Peak Flow Meter if used: 50 to 80% of personal best _____
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School Actions: Follow actions in marked boxes below

Take Quick-Relief Medication	How Much (Dose)	When	Start Date	Stop Date
MDI with Spacer: <input type="checkbox"/> Albuterol <input type="checkbox"/> Ventolin <input type="checkbox"/> Proventil <input type="checkbox"/> Xopenex Without spacer: <input type="checkbox"/> Maxair Autohaler	_____ puffs	Student report of symptoms	School Year	School Year
Nebulizer: <input type="checkbox"/> Albuterol <input type="checkbox"/> Ventolin <input type="checkbox"/> Proventil <input type="checkbox"/> Xopenex	_____ Unit Dose	Student report of symptoms	School Year	School Year

- ☐ If symptoms improve after 10-15 minutes: Return to normal activity
- ☐ If symptoms do not improve after 10-15 minutes: Give quick relief medication again and call parents
- ☐ If symptoms improve after the second 10-15 minutes: Return to normal activity and call parents
- ☐ If symptoms do not improve after the medication is repeated: Call EMS (911), School RN and parents
- ☐ If symptoms get worse at anytime: Call EMS (911), School RN and Parents
- ☐ Report frequent use of quick relief medications (twice a day for 3 days, not for exercise) to the School RN and Parents

Red Zone: Medical Alert (severe trouble breathing)	• Cannot stop coughing • Breathing fast • Flaring nostrils • Medication not helping • Getting worse, instead of better • Trouble walking or talking from shortness of breath • The skin between the ribs and above the collarbone pulls in or retracts • Lips or fingernails are blue
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- School Actions:**
1. Call EMS (911) IMMEDIATELY
 2. GIVE QUICK-RELIEVER MEDICATION AND CONTINUE EVERY 15 MINUTES UNTIL EMS (911) ARRIVES
 3. Call School RN and Parents

Take Quick-Relief Medications	How Much (Dose)	When	Start Date	Stop Date
MDI with Spacer: <input type="checkbox"/> Albuterol <input type="checkbox"/> Ventolin <input type="checkbox"/> Proventil <input type="checkbox"/> Xopenex Without spacer: <input type="checkbox"/> Maxair Autohaler	_____ puffs	Student report of or observation of symptoms.	School Year	School Year
Nebulizer: <input type="checkbox"/> Albuterol <input type="checkbox"/> Ventolin <input type="checkbox"/> Proventil <input type="checkbox"/> Xopenex	_____ Unit Dose	Student report of or observation of symptoms	School Year	School Year

Heath Care Provider Name: _____ Phone: _____ FAX#: _____

Health Care Provider Sign: _____ Date: _____

ASTHMA ACTION PLAN (page 2)

Student Name: _____ **Birthdate:** _____

Student Address: _____

Metered Dose Inhaler (MDI) Instructions

1. Store at room temperature
2. Shake the MDI for 5 seconds before each use.
3. Prime the MDI before the first use and according to instructions provided by your physician or medication information.
4. Keep track of metered inhalation puffs used.

MDI and Aerosol Solution Potential Adverse Reaction for any user: Headache, shakiness, rapid heart beat, nausea. Call parent with 1) student report of symptoms that interfere with school activities 2) increase in side effects 3) frequent usage (2 times a day for 3 consecutive days).

We have instructed the patient and family in the proper use of the quick-relief medications. It is my professional opinion that the student:

_____ should be allowed to carry and self administer the inhaled medication.

_____ should **not** carry and self administer the inhaled medication. The medication should be kept at school and designated school personnel should assist the student as needed with the medication administration.

Special Instructions: _____

Healthcare Provider Signature

Date

Physician emergency phone number

I give permission for my child to receive medication at school according to the school district policy and my healthcare provider's instructions and authorization. I agree to 1) assume responsibility for the safe delivery of the medication to school in its original container and with its original labels, 2) have a new form completed by my healthcare provider if the medication or dosage is changed in any way, 3) notify the school of changes in the healthcare provider or medication. If authorized by my healthcare provider, I permit my child to possess and use the prescribed medication at school or any activity, event, or program sponsored by or in which my child's school is a participant.

Parent/Guardian Signature: _____ **Date:** _____

Daytime Phone: _____