



Division of Special Education and Special Services
Health Services Department

Asthma Action Plan 20__ to 20__

Student's Name: _____ ID#: _____ DOB: _____

School: _____ School Phone#: _____ School Fax#: _____

Significant Medical History/ Diagnosis: _____

Allergies: _____

Asthma Triggers Identified: Exercise Colds Smoke (fire, tobacco, incense) Pollen Dust Strong Odors Mold/Moisture Stress Pests Gastroesophageal Reflux Season: Fall, Winter, Spring, Summer Animals Other (food allergies) _____

Emergency Contact: _____ Emergency Phone#: _____

Health Care Provider: Please complete Severity Level, Zone Information and Medical Order Below
Asthma Severity: Intermittent or Persistent: Mild Moderate Severe

Green Zone: GO –You're Doing Well!! Take Control Medications EVERYDAY to Prevent Symptoms

You have **ALL** of these:

- Breathing is easy
- No cough or wheeze
- Can work and play
- Sleep through the night

Peak flow may be useful for some students

NO Controller medication is prescribed

_____, _____ puff(s) MDI _____ times a day

_____, _____ Nebulizer Treatment _____ times a day

_____ _____

For asthma with exercise give:

Inhalers work better with spacers. Always use a mask when prescribed.

Yellow Zone: Slow Down! Continue Green Zone Medicine and Add:

You have **ANY** of these:

- **First signs of cold**
- Cough or mild wheeze
- Exposure to known trigger
- Tight Chest
- Coughing at night

Peak flow may be useful for some students

DO NOT LEAVE STUDENT ALONE! Call Parent/Guardian when rescue medication is given

_____, _____ puff(s) every _____ minutes/hours PRN (circle)

OR

_____, _____ Nebulizer Treatment _____ minutes/hours PRN (circle)

If you are getting worse or not improving after treatment(s) GO TO RED ZONE

Red Zone: DANGER—GET HELP! TAKE THESE MEDICATIONS NOW AND GET MEDICAL HELP NOW!

Your asthma is **getting worse fast:**

- Cannot talk, eat or walk well
- Medicine is not helping
- Getting worse, not better
- Breathing is hard & fast
- Getting nervous

DO NOT LEAVE STUDENT ALONE!

Call 911 and start treatment then call Parent/Guardian

_____ until EMS arrives

Check saturation with Pulse Oximeter continually until EMS arrives.

I, the undersigned, as the physician for the above-named student, approve the following health care procedure(s) to be administered to this student during school hours by trained staff. I agree that this authorization for the procedure(s) will stand for the current school year or until there is a change or cancellation of the procedure(s) during the current school year.

Inhaler is kept:

- with Student
- Is student capable of self-administration
- do you recommend that this child carry his/her own inhaler
- Student is to notify Nurse or UAP after use of inhaler at school.

To Be Completed by a Licensed Practitioner:

Length of Time for Present School Year:

Yes _____ No _____
If No for how long? _____

Practitioner's Signature

Practitioner's Name **Date**

Office Phone Number **Fax Number**

To Be Completed by The Parent/Guardian

- Yes No My child has my permission to carry his/her inhaler as ordered by the practitioner.
 - Yes No I give permission for my child to have his/her inhaler administered by trained school personnel.
- Signature : _____
Printed Name: _____
Date: _____ Relationship: _____

I, the undersigned, as the physician for the above-named student, approve the following health care procedure(s) to be administered to this student during school hours by trained staff. I agree that this authorization for the procedure(s) will stand for the current school year or until there is a change or cancellation of the procedure(s) during the current school year.

Inhaler is kept:

- with Nurse in Health Office
- Student needs supervision or assistance with using inhaler
- Student is unable to carry his/her inhaler while at school.

To Be Completed by a Licensed Practitioner

Length of Time for Present School Year:

Yes _____ No _____
If No for how long? _____

Practitioner's Signature

Practitioner's Name **Date**

Office Phone Number **Fax Number**

To Be Completed by The Parent/Guardian

- Yes No My child has my permission to carry his/her inhaler as ordered by the practitioner.
 - Yes No I give permission for my child to have his/her inhaler administered by trained school personnel.
- Signature: _____
Printed Name: _____
Date: _____ Relationship: _____

I approve of this asthma action plan. I give my permission for the school nurse and trained school personnel to follow this plan, administer medication(s), and contact my provider. I assume full responsibility for providing the school with the prescribed medications and delivery of monitoring devices. I give my permission for the school to share the above information with school staff that need to know. I do hereby give my consent for the release and exchange of information contained in the medical record of my child.

Parent's Signature **Phone Number** **Work Number** **Date**