ISD #728 School Health Services

ASTHMA ACTION PLAN

Physician: Complete this page **Parent/Guardian: Complete page 2**

Student _____ Date of Birth_____ Grade_____

Severity:	**Triggers/Allergies:**	**Symptoms:**	**Inhaler is Located:**
□ Mild Intermittent	□ Illness/Colds	□ Cough	□ Health Services
□ Mild Persistent	□ Exercise	□ Wheeze	□ Backpack
□ Moderate Persistent	□ Weather	□ Shortness of Breath	□ Self-carry
□ Severe Persistent	□ Environmental	□ Tightness in Chest	□ Other:_____
	□ Food:_____	□ Other:_____	
	□ Other:_____		

GREEN ZONE — DOING WELL — GO!

You have ALL of these:
- Breathing is good
- No cough or wheeze
- Can work/play easily

Step 1: Take these controller medicines every day:

Medication	**How Much**	**When**

Step 2: If exercise triggers your asthma, take the following medicine **15 minutes before** exercise.

Medication	**How Much**	**When**

YELLOW ZONE — GETTING WORSE — CAUTION!

You have ANY of these:
- It is hard to breathe
- Coughing
- Wheezing
- Tightness in chest
- Cannot work/play easily
- Anxious

Step 1: Keep taking **GREEN ZONE** medicines and **ADD** quick-relief medicine:
□ 2 or □ 4 puff(s) or nebulizer treatment of _____, once
Repeat inhaler every 20 minutes for up to 1 hour, if needed.

Step 2: Encourage slow breathing and offer warm water.

Step 3: Notify parent/guardian if needing quick relief medicine < 4 hours.

Step 4: If unable to reach parent and symptoms are **getting worse**, follow **RED ZONE** instructions.

RED ZONE — EMERGENCY — GET HELP NOW!

You have ANY of these:
- It is very hard to breathe
- Coughs continuously
- Nostrils open wide
- Ribs are showing
- Medicine is not helping
- Difficulty talking
- Lips or fingernails are blue or gray

Step 1: Take your quick-relief medicine **NOW**:

Medication	**How Much**

Or 1 nebulizer treatment of _____
AND

Step 2: Encourage slow breathing and offer warm water.

Step 3: Call **911**

Step 4: Notify parent/guardian.

Physician Authorization

I authorize the above plan to be followed in school.

Physician's Signature: _____ Printed Name of Physician: _____ Date: _____

Parent/Guardian: Complete this page

Student _____ Date of Birth_____ School _____ Grade_____

BUS INFORMATION: It is the parent's responsibility to notify the bus company directly of any specific directions for your child's care while riding the bus.

PARENT/GUARDIAN REQUEST FOR ADMINISTRATION OF MEDICATION

1. I request that the above medication(s) be given during school hours as ordered by this student's physician/licensed prescriber. I also request the medication(s) be given on field trips, as prescribed.
2. I release school personnel from liability in the event adverse reactions result from taking the medication(s).
3. I will notify Health Services of any change in the medication(s) i.e. dosage change, medication is discontinued, etc.
4. I give permission for the medication(s) to be given by school personnel as delegated by the school nurse.
5. If my child has any remaining medication(s) during or at the end of the school year, I authorize Health Services personnel to send it home with my child. I will notify Health Services if I prefer to pick up the medication(s) at school.
6. I understand that this action plan may be revoked at any time in writing and expires in one calendar year.
7. I authorize the above plan to be followed in school.

NOTE: Medication must be supplied in original/prescription bottle.

Parent/Guardian Signature: _____ Relationship to Student: _____ Date: _____

PERMISSION FOR RELEASE OF MEDICAL INFORMATION

1. I give permission for Health Services personnel to communicate as needed, with school staff about my child's medical condition(s).
2. I give permission for Health Services personnel to consult with my child's physician/licensed prescriber about any questions regarding the listed medication(s) or medical condition(s) being treated by the medication(s).
3. I give permission for the physician/licensed prescriber to release information related to the above medication(s) and medical condition(s) to Health Services personnel.

Parent/Guardian Signature: _____ Date: _____

SELF-CARRY INHALER CONTRACT (Secondary)

Based on student's knowledge and skills to safely possess, per Licensed School Nurse's discretion

I give permission for my child, _____ to carry their inhaler. My child understands that they must never share their inhaler with others and that they must go to Health Services with no improvement of symptoms. I will notify the school of changes in medication or my child's condition. **It is suggested to have a back-up inhaler that is kept in Health Services.**

Parent/Guardian Signature: _____ Date: _____

STUDENT AGREEMENT

I agree to:

- ☐ Follow my prescribing physician's medication orders.
- ☐ Use correct medication administration technique.
- ☐ Not allow anyone else to use my medication.
- ☐ Keep a supply of my medication with me in school and on field trips.
- ☐ Notify health office personnel if I used my inhaler and continue to have breathing difficulties.

Student signature: _____ Date: _____