

Asthma Action Plan

STUDENT INFORMATION:

Student Name (Last, First): _____ Birthdate: _____

School: _____ Teacher: _____ Grade: _____

TRIGGERS: Dust Exercise Illness Molds Pollen Smoke Weather (cold air, wind)
 Animals Emotions (e.g. when upset) Foods: _____ Other: _____
 Life Threatening allergy, specify: _____

HEALTHCARE PROVIDER TO COMPLETE ALL ITEMS BELOW: (PLEASE SIGN AND DATE BELOW)

QUICK RELIEF (RESCUE) MEDICATION: _____ Have student use SPACER with inhaler

COMMON SIDE EFFECTS: _____

CONTROLLER MEDICATION (Used at home): _____

GREEN ZONE: No symptoms Pretreat	* No current symptoms * Doing usual activities	Pretreat before exercise: <input type="checkbox"/> Not required <input type="checkbox"/> Routine <input type="checkbox"/> Parent/Student request Give QUICK RELIEF MED 10-15 minutes before activity: <input type="checkbox"/> 2 puffs <input type="checkbox"/> 4 puffs <input type="checkbox"/> Repeat in 4 hours, if needed for additional physical activity. If child is currently experiencing symptoms, follow YELLOW ZONE.
YELLOW ZONE: Mild symptoms	* Trouble breathing * Wheezing * Frequent cough * Not able to do activities, but talking in complete sentences	1. Stop physical activity. 2. Give QUICK RELIEF MED: <input type="checkbox"/> 2 puffs <input type="checkbox"/> 4 puffs 3. Stay with child and maintain sitting position. 4. REPEAT QUICK RELIEF MED if not improving in 15 minutes: <input type="checkbox"/> 2 puffs <input type="checkbox"/> 4 puffs 5. Child may go back to normal activities, once symptoms are relieved. 6. Notify parent/guardian and school nurse. If symptoms do not improve or worsen, follow RED ZONE
RED ZONE: EMERGENCY Severe symptoms	* Coughs constantly * Struggles to breathe * Trouble talking (only speaks 3-4 words) * Skin of chest and/or neck pull in with breathing * Lips/nails gray or blue * ↓ Level of consciousness	1. Give QUICK RELIEF MED: <input type="checkbox"/> 2 puffs <input type="checkbox"/> 4 puffs 2. Refer to anaphylaxis plan, if child has life-threatening allergy. 3. Call 911 4. Stay with child. Remain calm. Encourage slower, deeper breaths. 5. Notify parent/guardian and school nurse. 6. If symptoms do not improve, REPEAT QUICK RELIEF MED: <input type="checkbox"/> 2 puffs <input type="checkbox"/> 4 puffs (every 5 minutes until EMS arrives)

PROVIDER INSTRUCTIONS FOR QUICK RELIEF INHALER USE: CHECK APPROPRIATE BOX(ES):

Student needs supervision or assistance to use inhaler. Student will NOT self-carry inhaler. Medication in health office.
 Student understands proper use of asthma medications, and can carry and self-administer inhaler at school with approval from school nurse.
 Student will notify school staff after using quick relief inhaler, if symptoms do not improve with use.
As the prescribing physician in the event there is no school nurse, or other licensed person to administer medication, I authorize a trained unlicensed staff member to administer this prescribed medication to the above student.

HEALTH CARE PROVIDER SIGNATURE _____ DATE _____ STAMP: _____
 PRINT PROVIDER NAME _____ PHONE _____ FAX _____

PARENT/GUARDIAN TO COMPLETE

The parent/guardian of the above named student, request that this Asthma Action Plan be used to guide asthma care for my child. I agree to:
 1. Provide necessary supplies and equipment. 2. Notify nurse of any changes in the student's health status. 3. Notify the nurse and complete new consent for changes in orders I ACKNOWLEDGE IF MY STUDENT CARRIES AND ADMINISTERS HIS/HER OWN INHALER, IT MUST BE ON HIM/HER PERSON IN ORDER TO ATTEND A FIELD TRIP.
In agreeing to have the school administer my child's medication, I voluntarily agree to release, discharge, and hold harmless Roseville City School District and its officers, agents and employees for any and all claims of liability arising out of their negligence, recklessness or any other act of omission which cause my child's illness, injury, death, and damages of any nature in any way connected with the administration of medication. As the parent of the above student, in the event there is no school nurse or other licensed person to administer medication, I give consent for a trained unlicensed staff member to administer the prescribed medication to the above student. I understand that I may terminate the consent for the administration of the medication or for otherwise assisting the student in the administration of medication at any time. I authorize the District to communicate with the physician above regarding my child's medical condition and/or medication prescribed for it.

Parent/Guardian Signature: _____ Date: _____
 Parent/Guardian Name (Print): _____ Phone: _____