RCSD ROSEVILLE CITY SCHOOL DISTRICT Est. 1869

# 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)**

**DIAGNOSIS:** _____

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

**COMMON SIDE EFFECTS:** _____

**CONTROLLER MEDICATION** ***(Used at home)***: _____

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

_____ _____ STAMP:
MD/DO/PA SIGNATURE DATE

_____ _____ _____
**PRINT** MD/DO/PA 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: _____

School nurse signature: _____ Principal signature: _____