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: **No symptoms** **Pretreat**	* No current symptoms * Doing usual activities	Pretreat before exercise: ☐ Not required ☐ Routine ☐ Parent/Student request Give QUICK RELIEF MED 10-15 minutes before activity: ☐ 2 puffs ☐ 4 puffs ☐ 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: ☐ 2 puffs ☐ 4 puffs 3. Stay with child and maintain sitting position. 4. **REPEAT** QUICK RELIEF MED if not improving in 15 minutes: ☐ 2 puffs ☐ 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: ☐ 2 puffs ☐ 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: ☐ 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

Parent/Guardian (Authorization and Disclaimer): My signature above provides authorization for this Asthma Action Plan (AAP). I request that the school assist my child with the medications included in the AAP in accordance with state laws and regulations. Should the doctor determine that my child is competent to self-carry and self-administer the medications listed on the AAP, I agree to release the school district and school personnel from all claims of liability if my child suffers any adverse reactions from self-administration of the medications listed on the AAP. I understand that medication assistance may be performed by unlicensed, designated school personnel after the training by the school nurse. I authorize staff to communicate with the physician regarding my child's medical condition and/or the medications prescribed for it. I have read and agree with the information provided above. I understand and give my consent for this information to be shared with school, transportation, and emergency personnel as deemed necessary to provide quality of care. This consent is valid for one year from date unless otherwise stated and may be revoked at any time

Parent/Guardian Signature: _____ Date: _____

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

School nurse signature: _____ Principal signature: _____