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 know trigger • Tight Chest • Coughing at nigh 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/hoursPRN (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 <u>and</u> 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