Asthma Action Plan

Insert Student Photo Here	NAME:	Date of Plan:
	Patient ID:	Symptom Triggers:
	Age:	
	DOB:	Asthma Severity
	Home Phone:	

GREEN ZONE

The **GREEN ZONE** means taking the following medicine(s) every day.

GO! ALL CLEAR

>No cough, wheeze, chest tightness or shortness of breath during the day or night.
>Can do usual activities
Peak Flow Range:
0 to 0
80-100% of personal best

Daily Control Medicine(s)	Dosage

Take the following medicine if needed 10-20 minutes before sports, exercise, or any other strenuous activity

YELLOW ZONE

The **YELLOW ZONE** means taking the GREEN ZONE CONTROLLER medicine(s) every day and add the following medicine(s) to help keep the asthma symptoms from getting worse.

CAUTION

>Cough, wheeze, chest tightness, or shortness of breath, or
>Waking at night due to asthma or,
>Can do some, but not all, usual activities
Peak Flow Range:
0 to 0
50-80% of personal best

Quick Reliever Medicine(s)	Dosage

If worsening, call your doctor before starting oral steroids

Use Quick Reliever 2-4 puffs, every 20 minutes for up to 1 hour or use nebulizer once.
If your symptoms are not better or you do not return to the GREEN ZONE after 1 hour, follow RED ZONE instructions.

RED ZONE

The **RED ZONE** means start taking your RED ZONE medicine(s) and
Call Your Doctor NOW!
Take these medications until you talk with your doctor.
If your symptoms do not get better and you can't reach your doctor,
Go to the emergency room or call 911 immediately.

STOP! MEDICAL ALERT!

>Very short of breath, or
>Quick-relief medicine(s) have not helped, or
>Cannot do usual activities, or
>Symptoms are same or get worse after 24 hours in Yellow Zone
Peak Flow Range:
0 to 0
Below 50% of personal best

Continue Quick Relief and add Burst Medicine & Dose

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☐ This Asthma Plan provides authorization for the administration of medications.

☐ This child has the knowledge and skills to self-administer rescue medication at school

I give my permission for the asthma action plan to be used by the following in order to share information with each other about my child's asthma. I understand this authorization is for one year, but may be revoked at any time per my request, submitted by phone or in writing. (Add names for those that apply)

MD/NP/PA	School/School health officer	Clinic hospital
Day care provider	Coach	Other

Physician ______________________ **Signature** ______________________

Phone ______________________

Parent/Guardian ______________________ **Signature** ______________________

REV 5/6/2014

Student Name: ______________________________

TO BE COMPLETED BY PARENT/GUARDIAN

EMERGENCY CONTACTS

Mother/Guardian		Father/Guardian	
	Name:		Name:
	Home Phone:		Home Phone:
	Work Phone:		Work Phone:
	Other:		Other:

ADDITIONAL EMERGENCY CONTACTS

1.	Relationship:	Phone:
2.	Relationship:	Phone:

My student may carry his/her own asthma inhaler? ☐ Yes ☐ No
My student is trained to self-administer inhaler? ☐ Yes ☐ No **Provide extra inhaler for office?** ☐Yes ☐No

Parent:

- I understand that the school board or the school district's employees cannot be held responsible for negative outcomes resulting from self-administration of the inhaled asthma medication.
- This permission to possess and self-administer asthma medication may be revoked by the principal/school nurse if it is determined that the student is not safely and effectively self-administering the medication.
- A new LHP order/Emergency Care Plan (ECP) for asthma and parent/student agreement for an inhaler must be submitted each school year.
- I understand that if any changes are needed on the ECP, it is the parent's responsibility to contact the school nurse.
- I give consent for the implementation of this Section 504 plan.

I have reviewed the information on this School Asthma Plan and Medication Orders and request/authorize trained school employees to provide this care and administer the medications in accordance with the Licensed Healthcare Provider's (LHP's) instructions. I authorize the exchange of medical information about my child's asthma between the LHP office and school nurse.

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Parent/Guardian Signature **Date**

◊ **Written Notice for Health Care/Section 504 Plan**: The purpose of this written notice is to inform you that the District is proposing to ☐ **Initiate OR** ☐**Change/Update** your child's Health Care/Section 504 Plan as described above. A copy of *Your Rights Under Section 504* is attached or can be found at http://bisd303.org/Page/499.

Student:

- I have demonstrated the correct use of the inhaler to the medical provider and/or school nurse.
- I agree never to share my inhaler with another person or use it in an unsafe manner.
- I agree that if there is no improvement after self-administering, I will report to an adult at school if the nurse is not available or present.

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Student Signature **Date**

All school-aged students who use asthma medication(s) at school must have a current School Asthma Plan completed and signed by their health care professional and kept on file in the school office (RCW 28A.210.320.370). The form must also be signed by a parent/guardian. The plan must be updated each year and when there are major changes to the plan (such as in medication type or dose). The provider's office is encouraged to fax the plan to the student's school nurse.

The school plan is intended to strengthen the partnership of families, healthcare providers and the school. It is based on the NHLBI Guidelines for Asthma Management.

CARRYING AND ADMINISTERING AND QUICK RELIEF INHALERS:

▶ Most students are capable of carrying and using their quick relief inhaler by themselves. The student, student's parents, school nurse and health care provider should make this decision. The school nurse should also evaluate technique for effective use.

For District Nurse's Use Only

Student has demonstrated to the nurse, the skill necessary to use the medication and any device necessary to self-administer the medication

Device(s) if any, used: Expiration date(s):

School Nurse Signature **Date**