High School Fax:(610)987-4300

Asthma Action Plan

To be completed by the physician and signed by both physician and parent

Effective Date: _____ to _____

Student's Name: _____ Birth Date: _____

Homeroom Teacher: _____ Grade: _____

Physician's printed name _____ Phone _____

Parent/Guardian: _____

Phone: Home_____ Business _____ Cell_____

Emergency Contact after parent: _____ Phone_____

Asthma Severity: ___Mild Intermittent ___Mild Persistent ___Severe Persistent

Asthma Triggers: ___Colds ___Exercise ___Animals ___Dust ___Smoke ___Food ___Weather ___Other:

TAKE THESE MEDICINES EVERYDAY (Green Zone)

Child feels good:	Medicine:	How Much:	When To Take It:
-Breathing is good			
-No Cough or wheeze			
-Can work/play			
-Sleeps at night			

Peak flow in this area:
_____ **to** _____

20 MINUTES BEFORE EXERCISE USE THIS MEDICINE:

_____	_____	_____
Name	**Dosage**	**Route**

TAKE EVERYDAY MEDICINES AND THESE RESCUE MEDICINES (Yellow Zone)

IF NOT FEELING WELL

Child has any of these:	Medicine:	How Much:	When To Take It:
-Cough			
-Wheeze			
-Tight Chest			

Peak flow in this area:
_____**to** _____

Call your doctor/nurse's office if the symptoms don't improve in 2 days OR if the flare lasts for for longer than _____ days. After _____ days go back to GREEN ZONE and take everyday medications as instructed.

IF FEELING VERY SICK CALL THE DOCTOR OR NURSE NOW! TAKE THESE MEDICINES (Red Zone)

Child has <u>any</u> of these:	Medicine:	How Much:	When To Take It:
-Medicine not helping			
-Breathing is hard and fast			
- Lips and fingernails are blue			
-Can't walk or talk well			

Peak flow below:

_____

IF UNABLE TO CONTACT YOUR DOCTOR OR NURSE:

Call 911 or go to the nearest emergency room and bring this form with you!

PLEASE COMPLETE <u>BOTH</u> SIDES OF THIS FORM

Students will be permitted to possess and use Asthma Inhalers in school with permission from their physician, parents, and the school nurse only to permit immediate access to this emergency medication in order to prevent a life-threatening crisis and not for the convenience of daily administration. Students must report to the nurse's office when routine daily administration is required.

☐ I have instructed _____ in the proper way to use his/her Asthma Inhaler and it is my professional opinion that this student **should be allowed** to carry and use this medication by him/herself.

☐ It is my professional opinion that _____ should not carry his/her Asthma Inhaler. This medication will be kept in the nurse's office and administered by the nurse.

Physician's Signature _____ **Date** _____

Physician's Name Printed _____
Name of Practice _____ **Office Phone #** _____

To carry and self administer Asthma Inhaler medication: the student must demonstrate to the school nurse the capability for proper self-administration and responsible behavior in assuring that medication availability is restricted from other students. The student must notify the school nurse immediately following each use of an Asthma Inhaler. The medication will be confiscated and student privileges lost if school policies are abused or ignored.

As the parent/guardian of the above named student, I relieve the school district and its employees of any responsibility for the benefits or consequences of the above listed medication when it is physician prescribed and parent/guardian authorized. I further acknowledge that the school bears no responsibility for ensuring that the medication is taken. I am aware that this student must notify the school nurse immediately following each use of the above prescribed medication, and that the medication will be confiscated and student privileges lost if school policies are abused or ignored.

I give permission to the doctor, nurse, health plan, and other health care providers to share information about my child's asthma to help improve the health of my child.

Parent/Guardian Signature _____ **Date** _____

To carry and self administer Asthma Inhaler medication: I agree to be solely responsible for my Asthma Inhaler and to follow the directions for its use as ordered by my physician, and the district's medication policy. I am aware that ignoring district policies or abusing this privilege will result in the confiscation of my inhaler and loss of my privilege to self administer my medication. I will demonstrate responsible behavior at all times by assuring that my prescribed medication is not shared with, or in any way made available to, other students.

Student's Signature _____ **Date** _____