Asthma Action Plan

Student Name ______________________ Grade ________ School year ____/____

Doctor: ______________________ Date: ______________

Doctor's Phone Number ______________ Hospital/Emergency Department Phone Number ______________

GREEN ZONE

Doing Well

- No cough, wheeze, chest tightness, or shortness of breath during the day or night
- Can do usual activities

And, if a peak flow meter is used,

Peak flow: more than __________
(80 percent or more of my best peak flow)

My best peak flow is: __________

Take these long-term control medicines each day (include an anti-inflammatory).

Medicine	How much to take	When to take it

Before exercise	p __________	p 2 or p 4 puffs __________	5 minutes before exercise

YELLOW ZONE

Asthma Is Getting Worse

- Cough, wheeze, chest tightness, or shortness of breath, or
- Waking at night due to asthma, or
- Can do some, but not all, usual activities

-Or-

Peak flow: ________ to ________
(50 to 79 percent of my best peak flow)

Add: quick-relief medicine—and keep taking your GREEN ZONE medicine.

__________________ (short-acting $beta_2$-agonist)
p 2 or p 4 puffs, every 20 minutes for up to 1 hour
p Nebulizer, once

If your symptoms (and peak flow, if used) return to GREEN ZONE after 1 hour of above treatment:
p Continue monitoring to be sure you stay in the green zone.

-Or-

If your symptoms (and peak flow, if used) do not return to GREEN ZONE after 1 hour of above treatment:
p Take: __________________ (short-acting $beta_2$-agonist) p 2 or p 4 puffs or p Nebulizer
p Add: __________________ (oral steroid) mg per day For ________ (3–10) days
p Call the doctor p before/ p within ________ hours after taking the oral steroid.

RED ZONE

Medical Alert!

- Very short of breath, or
- Quick-relief medicines have not helped, or
- Cannot do usual activities, or
- Symptoms are same or get worse after 24 hours in Yellow Zone

-Or-

Peak flow: less than __________
(50 percent of my best peak flow)

Take this medicine:

p __________________ (short-acting $beta_2$-agonist) p 4 or p 6 puffs or p Nebulizer

p __________________ (oral steroid) mg

Then call your doctor NOW. Go to the hospital or call an ambulance if:
- You are still in the red zone after 15 minutes AND
- You have not reached your doctor.

DANGER SIGNS
- Trouble walking and talking due to shortness of breath
- Lips or fingernails are blue

- Take p 4 or p 6 puffs of your quick-relief medicine AND
- Go to the hospital or call for an ambulance __________ (phone) NOW!

Asthma Action Plan - United School District

Consent form for *carrying and self-administering* asthma medication during school hours

Student ______________________________ Grade________

This section is to be completed by the child's health care provider if they want the child to **carry and self-administer** the medication. *(Otherwise the medication is to be kept in the school nurse's office and administered by the school nurse).*

Medication ______________________________

Dose/Frequency ______________________________

Indication ______________________________

Potential side effects ______________________________

The above named student has been taught and is qualified and able to carry and self-administer the above stated medication:

Healthcare Provider signature ______________________________Date________

This section to be completed by the parent/guardian

I agree to allow my child to carry and self-administer the above stated medication. I release the United School District and its employees of any responsibility for the benefits or consequences of the self-administered medication.

Parent/Guardian signature______________________________ Date__________

United School District Medication Administration Form/Policy

Dear Parent/Guardian,

The United School District has guidelines regarding the administration of medication during school hours. This includes all medication, both prescription and over-the-counter. The complete policy can be found in the parent/student handbook. The following conditions must be met for a student to receive medication during the school day:

- All medication must have written orders from a physician.
- All medication must have written consent from the parent/guardian.
- Medication must be in the original prescription container with the student's name and prescription label in place.
- If your child must receive medication during school hours, please complete the lower portion of this form and return it to the school. The physician may fax the completed form to 814-446-5615 (high school) or 814-446-4210 (elementary school). Thank you for your cooperation in this matter.

  School Health Office

  Elem-814-446-5615 #1319, High School 814-446-5615 #2339

- -

Student ________________________________ Grade ____________

United School District has permission for the School Health Office to administer the following medication during school hours:

Medication ____

Dosage ________________________ Route ____________________

Time ______________________ Start Date ________ End date _________

Indication ____

Potential side effects ______________________________________

Parent/Guardian Signature ________________________ Date ___________

Physician Signature ____________________________ Date ___________