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)

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 assistive person/trained health care aid to administer this prescribed medication to the above student.

_____ _____ STAMP:
HEALTH CARE PROVIDER SIGNATURE DATE

_____ _____ _____
PRINT PROVIDER NAME PHONE FAX

SEE PAGE 2 FOR PARENT/GUARDIAN TO COMPLETE

PARENT/GUARDIAN TO COMPLETE

The parent/guardian of the above named student, request that this Asthma Action Plan be used to guide asthma care for my child. I agree to:
1. Provide necessary supplies and equipment. 2. Notify nurse of any changes in the student's health status. 3. Notify the nurse and complete new consent for changes in orders.

I ACKNOWLEDGE IF MY STUDENT CARRIES AND ADMINISTERS HIS/HER OWN INHALER, IT MUST BE WITH THEM IN ORDER TO ATTEND A FIELD TRIP.

In agreeing to have the school administer my child's medication, I voluntarily agree to release, discharge and hold harmless Rocklin Academy Family of Schools and its officers, agents and employees for any and all claims of liability arising out of their negligence, recklessness or any other act of omission which cause my child's illness, injury, death, and damages of any nature in any way connected with the administration of medication. I acknowledge and understand the medication may be administered by a school nurse or by designated school personnel. I understand that I may terminate the consent for the administration of the medication or for otherwise assisting the student in the administration of mediation at any time. I have read and understand the RAFOS Administration of Medications Policy and understand medication will only be delivered consistent with this Policy. I authorize the school to communicate with the physician below regarding my child's medical condition and/or medication prescribed for it.

Parent/Guardian Signature: _____ Date: _____

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

School Nurse Signature: _____ 06/18