School Asthma Action Plan

Student Name: _____ **DOB:** _____ **Grade:** _____
Parent/Guardian's Name/ phone number: _____
Alternate phone number for guardian: _____

PERSONAL ASTHMA TRIGGERS: __pollen __mold __ dust/dust mites __fumes __cold air __humidity __respiratory infection __smoke __ animal/animal dander (type)_____ __exercise (type)_____ __food(type)_____ __medication (type)_____

USUAL ASTHMA SYMPTOM (check all that applies):
__ wheezing __coughing __difficulty breathing __shortness of breath __Other_____

PHYSICAL ED/ RECESS: __Full participation at all times, no asthma restriction
__Full participation unless symptoms present or develops
__Participation with the following modifications:
__allow student to self pace __warm up exercises __built in rest periods,as needed
__peak flow must be above ___ __short duration aerobic activities, as tolerated
__indoor alternative if outside temp is below __degrees __Other _____

PREVENTION: LIST ANY ENVIRONMENTAL CONTROL MEASURES, DIETARY RESTRICTIONS,OR OTHER FACTORS NEEDED TO PREVENT AN ASTHMA EPISODE: _____

STEPS TO TAKE DURING AN ASTHMA EPISODE:

GREEN ZONE	Child feels good. No wheezing, no cough, no difficulty breathing.	NO ACTION NEEDED	
YELLOW ZONE	Child's breathing feels tight, have mild wheezing or cough. Child's peak flow is at____	Give PRN/RESCUE medication as follows: Medication/ Route: _____ Amount(Indicate if repetition needed): _____ Side Effects: _____ _____	Have Student return to class if symptoms resolve within _____ minutes. Contact parent regarding episode.
RED ZONE	Symptoms persist, child have difficulty breathing, actively wheezing, peak flow is ___ or less	DO AS FOLLOWS: _____ _____ _____	**IF CHILD HAS ANY OF THE FOLLOWING DANGER SIGNS, CALL 911:** - chest sucking in during breathing - nostrils wide open - very difficulty breathing - trouble talking or walking - lips or fingernails blue or purple

****Medical Provider please check any of the following that applies:**
__ This child may carry own rescue medication on his/her body, and may admnister medication in the presence of an adult. He/ She has been trained to administer own medication by his/her physician and parent/guardian.
__ This child's medical condition does not require medication to be available while in school(MD , please initial if it's the case).

Medical provider name/ Signature: _____ **Tel #:** _____

PARENT INSTRUCTIONS (PLEASE CHECK ALL THAT APPLY)

- If school is unable to reach parent in an emergency, permission is granted to contact physician listed or arrange to transport to the emergency room.

- This student must carry an inhaler at all times, because of the severity of asthma, and is deemed responsible with the use of the inhaler. Ideally, a back-up inhaler will be kept with the nurse. The student will see the nurse if the medication is not effective and agrees to check in periodically with the nurse for monitoring.

- This student has been instructed in the proper use of his/her medication. He/She understands how to manage asthma and can do so in school, under direct supervision of the nurse.

- This student needs assistance from the nurse in administrating his/her medication, and will require assistance in regulating his/her activity and monitoring peak flow levels.

- I/we agree to release this information to the following staff members as appropriate, with the exception that confidentiality will be respected at all times:

___Health staff	___Teachers	___ School Administrators
___PE Teacher(s)	___ Substitute teacher	___Special-ed teacher
___Recess/ lunchroom staff	___Bus personnel	

_____ _____

Parent Signature Date