ASTHMA ACTION PLAN

Name: _____ **Birthdate:** _____

Student ID: _____ **Grade:** _____ **Campus:** _____

PROMISE2PURPOSE

TO BE COMPLETED BY HEALTH CARE PROVIDER

MEDICATION: _____

DOSAGE: _____

SIDE EFFECTS: _____

ADMINSTRATION

☐ With Spacer

☐ As Needed Every _____ Hours

☐ 15 minutes prior to exercise if needed

GREEN ZONE	YELLOW ZONE	RED ZONE
Breathing is good No cough or wheeze Can work and play	Some problems breathing Cough, wheeze or chest tight Problems playing	Wheezing, Can't talk well Breathing hard and fast Nose opens when child breathes
Follow regular medication plan	Give _____ puffs of inhaler _____ minutes apart. Monitor student to check for zone change.	Follow **EMERGENCY PLAN**

EMERGENCY PLAN - when the student exhibits symptoms from the RED ZONE:

- Give _____ puffs of inhaler or 1 nebulized treatment.
- If no improvement, treatment can be repeated _____ times _____ minutes apart.
- **If no improvement after a total of _____treatments call 911 and notify parent.**

☐ The inhaler must be kept in the school clinic. Student is not allowed to carry inhaler with them.

☐ This student has been educated and is knowledgeable about asthma and can properly self-administer the prescribed medication. He/ She has been instructed in the proper handling and carrying of the inhaler and that it must be kept out of the reach of other students at all times. He/ She are aware the inhaler must have a current prescription label indicating that it has been prescribed for them. Please allow him/her to carry the inhaler with them while on school property or at school related events.

_____ _____ _____

Health Care Provider Signature | Printed Name | Date

Tel #: _____ Fax #: _____

TO BE COMPLETED BY PARENT

I request that inhaler be administered to my child according to the signed protocol from my Health Care Provider. I hereby give my permission for the school nurse to consult with the prescribing physician regarding the above orders.

Parent's Signature: _____ Printed name: _____

Date: _____ Emergency phone numbers: _____