ASHWAUBENON SCHOOL ASTHMA ACTION PLAN

Name: **Date:**

DOB: **Phone:**

Parent/Guardian: **Cell Phone:**

Emergency Contact: **Phone:**

Doctor:

Triggers: ☐Weather (cold air, wind) ☐ Illness ☐ Exercise ☐ Smoke ☐Dog/Cat ☐ Dust ☐ Mold ☐ Pollen
Other:

GREEN ZONE: **PRETREATMENT STEPS FOR EXERCISE**

☐Give 2 puffs of rescue med (name) : 15 minutes before activity (Gym, exercise, recess).
☐Repeat in 4 hours if needed for additional or ongoing physical activity

YELLOW ZONE: **UNCONTROLLED ASTHMA** (Health Provider complete dosing for rescue inhaler)

If you see this:	DO THIS:
• Difficulty breathing • Wheezing • Frequent cough • Complaints of chest tightness • Unable to tolerate regular activity but still able to talk • Other:	• Stop physical activity • Giver rescue med (name): ☐ 1 puff ☐ 2 puffs ☐ via spacer ☐ other_____ • If no improvement in 10-15 minutes, repeat use of rescue med: ☐ 1 puff ☐ 2 puffs ☐ via spacer ☐ other_____ • Stay with student and maintain sitting position • Call parents/guardian and school nurse • If symptoms do not improve or worsen CALL 911 • Student may resume normal activity once feeling better

- If there is **no rescue medication at school**
  - Call parent/guardians to pick up student or bring medication to school
  - Inform parent/guardian that if they cannot get to school 911 may be called

RED ZONE: **EMERGENCY SITUATION** (Health Provider complete dosing for rescue inhaler)

If you see this:	DO THIS IMMEDIATELY:
•Coughs constantly •Struggles or gasps for breath •Trouble talking (can speak only 3-5 words) •Skin of chest and/or neck pull in with breathing •Lips or fingers blue or gray •Decrease Level of consciousness	• Giver rescue med (name): ☐ 1 puff ☐ 2 puffs ☐ via spacer ☐ other_____ • Repeat rescue med if student not improving in 10-15 minutes ☐ 1 puff ☐ 2 puffs ☐ via spacer ☐ other_____ • CALL 911 –inform 911 reason for call student with asthma • Call parents/guardian and school nurse • Encourage student to take slow deep breaths • Stay with student and remain calm

INSTRUCTIONS for RESCUE INHALER USE: (HEALTH PROVIDER: PLEASE CHECK APPROPRIATE BOX(ES)

☐Student understand the proper us of his/her medications and in my opinion **can carry and use his/her inhaler at school independently.**
☐Student can self-carry inhaler at school
☐Student needs supervision or assistance to use his/her inhaler. Inhaler will be located in the Office/Health room.
☐Student has a life-threatening allergy; the epi-pen is located in the **Office/Health Room**, or _____.

_____ _____

HEALTH CARE PROVIDER SIGNATURE **PLEASE PRINT NAME** **DATE**

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our physician. I assume full responsibility for providing the school with prescribed medication and delivery devices. I approve of this Asthma Action plan for my child.

_____ _____

Parent Signature Date: School Nurse Signature _____