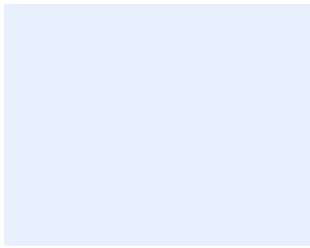


ASHWAUBENON SCHOOL ASTHMA ACTION PLAN

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:
<ul style="list-style-type: none"> • Difficulty breathing • Wheezing • Frequent cough • Complaints of chest tightness • Unable to tolerate regular activity but still able to talk • Other: 	<ul style="list-style-type: none"> • Stop physical activity • Giver rescue med (name): <input type="checkbox"/> 1 puff <input type="checkbox"/> 2 puffs <input type="checkbox"/> via spacer <input type="checkbox"/> other _____ • If no improvement in 10-15 minutes, repeat use of rescue med: <input type="checkbox"/> 1 puff <input type="checkbox"/> 2 puffs <input type="checkbox"/> via spacer <input type="checkbox"/> 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:
<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Giver rescue med (name): <input type="checkbox"/> 1 puff <input type="checkbox"/> 2 puffs <input type="checkbox"/> via spacer <input type="checkbox"/> other _____ • Repeat rescue med if student not improving in 10-15 minutes <input type="checkbox"/> 1 puff <input type="checkbox"/> 2 puffs <input type="checkbox"/> via spacer <input type="checkbox"/> 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 use 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 _____