



Student Services
Health Care Action Plan –Asthma

Please return form to: School: _____ Fax: _____

Name: _____ DOB: _____

Symptoms and History of Asthma Attacks

Blank area for recording symptoms and history of asthma attacks.

Medications available at school for treatment

Blank area for listing medications available at school for treatment.

School accommodations and treatments

Blank area for detailing school accommodations and treatments.

Name:	Birth date:
Teacher:	Grade:
Parent/Guardian:	Cell Phone:
Home Phone:	Work Phone:
Other Contact:	Phone:
Preferred Hospital:	

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

GREEN ZONE: PRETREATMENT STEPS FOR EXERCISE (Health provider initial all that apply)

- Give 2 puffs of rescue med _____ 15 minutes before activity (Circle indication: Phys Ed class, exercise/sports, recess) Explanation: _____
- Repeat in 4 hours if needed for additional or ongoing physical activity

YELLOW ZONE: SICK – UNCONTROLLED ASTHMA (Health provider complete dosing for rescue inhaler)

IF YOU SEE THIS:	DO THIS:
<input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Wheezing <input type="checkbox"/> Frequent cough <input type="checkbox"/> Complains of chest tightness <input type="checkbox"/> Unable to tolerate regular activities but still talking in complete sentences <input type="checkbox"/> Other: _____	<input type="checkbox"/> Stop physical activity <input type="checkbox"/> Give rescue med (<i>name</i>): _____ <input type="checkbox"/> 1 puff <input type="checkbox"/> 2 puffs <input type="checkbox"/> other: _____ <input type="checkbox"/> Via spacer <input type="checkbox"/> 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"/> other: _____ <input type="checkbox"/> Via spacer <input type="checkbox"/> If student's symptoms do not improve or worsen, call 911 <input type="checkbox"/> Stay with student and maintain sitting position <input type="checkbox"/> Call parents/guardians and school nurse <input type="checkbox"/> Student may resume normal activities once feeling better

- If there is **no rescue inhaler at school**:
 - Call parents/guardians to pick up student and/or bring inhaler/ medications to school
 - Inform them 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:
<input type="checkbox"/> Coughs constantly <input type="checkbox"/> Struggles or gasps for breath <input type="checkbox"/> Trouble talking (only able to speak 3-5 words) <input type="checkbox"/> Skin of chest and/or neck pull in with breathing <input type="checkbox"/> Lips or fingernails are gray or blue <input type="checkbox"/> ↓ Level of consciousness	<input type="checkbox"/> Give rescue med (<i>name</i>): _____ <input type="checkbox"/> 1 puff <input type="checkbox"/> 2 puffs <input type="checkbox"/> Other: _____ <input type="checkbox"/> Via spacer <input type="checkbox"/> Repeat rescue med if student not improving in 10-15 minutes <input type="checkbox"/> 1 puff <input type="checkbox"/> 2 puffs <input type="checkbox"/> Other: _____ <input type="checkbox"/> Via spacer <input type="checkbox"/> Call 911 Inform attendant the reason for the call is asthma <input type="checkbox"/> Call parents/guardians and school nurse <input type="checkbox"/> Encourage student to take slower deeper breaths <input type="checkbox"/> Stay with student and remain calm <input type="checkbox"/> <i>School personnel should not drive student to hospital</i>

- INSTRUCTIONS for RESCUE INHALER USE: (HEALTH PROVIDER: PLEASE CHECK APPROPRIATE BOX(ES))**
- Student understands the proper use of his/her asthma medications, and in my opinion, can carry and use his/her inhaler at school independently
 - Student is to notify his/her designated school health officials after using inhaler
 - Student needs supervision or assistance to use his/her inhaler. If not self carry, the inhaler is located: _____
 - Student has life threatening allergy, the epipen is located: _____

HEALTH CARE PROVIDER SIGNATURE _____ PLEASE PRINT PROVIDER'S 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/monitoring devices. I approve this Asthma Care Plan for my child.

 School Nurse Signature _____ DATE _____ 504 Plan or IEP

Copies of plan provided to: Teachers ___ Phys Ed/Coach ___ Principal ___ Main Office ___ Bus Driver ___ Other _____

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