



SCHOOL ASTHMA ACTION PLAN

Name		School		Class	Grade
Emergency Contact			Cell/Phone		Date of Birth
Triggers: <input type="checkbox"/> Mold/Pollens <input type="checkbox"/> Animals <input type="checkbox"/> Colds <input type="checkbox"/> Dust <input type="checkbox"/> Exercise <input type="checkbox"/> Smoke <input type="checkbox"/> Weather <input type="checkbox"/> Fragrance					
Green Zone: Doing Well:					
		•Breathing is good		•No cough or wheeze	
		•No early warning signs		•Can work and play	
		•Peak Flow Meter if used: 80-100% of personal best _____		•Sleeps all night	
School Action: Follow actions in marked boxes below for exercise induced asthma.					
<input type="checkbox"/> Medication Before Exercise		<input type="checkbox"/> Medication Before Recess		<input type="checkbox"/> Use Routinely every _____ hours	
Medication with spacer: <input type="checkbox"/> Albuterol <input type="checkbox"/> Ventolin <input type="checkbox"/> Proventil <input type="checkbox"/> Xopenex		Medication without spacer: <input type="checkbox"/> Maxair Autohaler			
Dose: _____ puffs When: 10-15 minutes before listed activity Start Date: School Year _____ Stop Date: School Year _____					
Yellow Zone: Getting Worse (mild trouble breathing)					
		•Cough, wheeze, chest tight		•Problems working/playing	
		•Shortness of breath		•Peak Flow Meter if used: 50-80% of personal best _____	
School Actions: Follow actions in marked boxes below.					
Take Quick-Relief Medication		How Much (Dose)	When	Start Date	Stop Date
MDI with Spacer: <input type="checkbox"/> Albuterol <input type="checkbox"/> Ventolin <input type="checkbox"/> Proventil <input type="checkbox"/> Xopenex Without spacer: <input type="checkbox"/> Maxair Autohaler		_____ puffs	Student report of symptoms	School Year	School Year
Nebulizer: <input type="checkbox"/> Albuterol <input type="checkbox"/> Ventolin <input type="checkbox"/> Proventil <input type="checkbox"/> Xopenex		_____ Unit Dose	Student report of symptoms	School Year	School Year
<input type="checkbox"/> If symptoms improve after 10-15 minutes: Return to normal activity <input type="checkbox"/> If symptoms do not improve after 10-15 minutes: Give quick relief medication again and call parents <input type="checkbox"/> If symptoms improve after the second 10-15 minutes: Return to normal activity and call parents <input type="checkbox"/> If symptoms do not improve after the medication is repeated: Call EMS (911), School RN and parents <input type="checkbox"/> If symptoms get worse at any time: Call (911), School RN and parents <input type="checkbox"/> Report frequent use of quick relief medications (twice a day for three (3) days, not for exercise) to the School RN and parents					
Red Zone: Medical Alert (severe trouble breathing)		•Cannot stop coughing Breathing fast •Flaring nostrils •Medication not helping •Trouble walking or talking from shortness of breath •Getting worse instead of better •Lips or fingernails are blue •Skin between the ribs and above the collarbone pulls in or retracts			
School Actions:					
1. CALL EMS (911) IMMEDIATELY 2. GIVE QUICK-RELIEVER MEDICATION AND CONTINUE EVERY 15 MINUTES UNTIL EMS (911) ARRIVES 3. Call School RN and parents					
Take Quick-Relief Medication		How Much (Dose)	When	Start Date	Stop Date
MDI with Spacer: <input type="checkbox"/> Albuterol <input type="checkbox"/> Ventolin <input type="checkbox"/> Proventil <input type="checkbox"/> Xopenex Without spacer: <input type="checkbox"/> Maxair Autohaler		_____ puffs	Student report of or observation of symptoms	School Year	School Year
Nebulizer: <input type="checkbox"/> Albuterol <input type="checkbox"/> Ventolin <input type="checkbox"/> Proventil <input type="checkbox"/> Xopenex		_____ Unit Dose	Student report of or observation of symptoms	School Year	School Year
Health Care Provider Name:			Phone:	Fax#:	
Health Care Provider Signature:			Date:		

Student Name: _____ Birth Date: _____

School Asthma Action Plan

Metered Dose Inhaler (MDI) Instructions

1. Store at room temperature.
2. Shake the MDI for 5 seconds before each use.
3. Prime the MDI before the first use or when not used every day. Follow the product's patient information sheet for MDI specific priming instructions. Priming usually involves pressing down on the medication canister to discard into the air one (1) or more puff of medication. Discarding puffs makes sure the next puff inhaled contains the labeled amount of medication.
4. Keep track of metered inhalation puffs used. Subtract the number used from the number of metered inhalation puffs available listed on the label. The number of metered inhaled puffs available is listed on the medication canister or on the box. There are usually 200 puffs in an MDI.
5. Ask family for a new MDI when all labeled metered inhalation puffs are used.

MDI and Aerosol Solution Potential Adverse Reaction: Headache, shakiness, fast heart rate, nausea. Call parent with 1) student report of symptoms that interfere with school work or activity 2) increase in side effects 3) frequent usage (2 times a day for 3 days).

We have instructed the patient and family in the proper use of the quick-relief medications. It is my professional opinion that the student:

_____ should be allowed to carry and self administer the inhaled medication.

_____ should **not** carry and self administer the inhaled medication. The medication should be stored and administered by designated school personnel.

Provider Signature: _____ Date: _____

Section II To Be Completed by Parent

I give permission for my child to receive medication at school in keeping with Section I above according to the school district policy and as instructed by the physician and agree to 1) Assume responsibility for safe delivery of the medication in its original container to the school, 2) Have a new form completed by the doctor if medication or dosage is changed, 3) Notify the school of changes in health care provider. I release from liability, and in addition agree to indemnify, all school employees, the Board of Education and Akron Children's Hospital School Health Services for damages or injury resulting from the use, misuse or nonuse of such medication except as such Board, School Health Services or its employees are grossly negligent or engage in wanton or reckless misconduct. I further agree to submit a revised statement signed by the physician who has prescribed the medication described in Section I in the event that I become aware that any of the above information has changed. I have read and understand the policy of the School Board for administration of medication and affirm that this request entails special circumstances justifying an exception from the usual administration of medication at school-by-school personnel.

Parent/Guardian Signature: _____ Date: _____

Daytime Phone: _____

THIS FORM EXPIRES AT THE END OF THE SCHOOL YEAR