Asthma Action Plan

Date Completed

Name	Date of Birth	Grade/Teacher
Health Care Provider	Health Care Provider's Office Phone	Medical Record Number
Parent/Guardian	Phone	Alternate Phone
Parent/Guardian/Alternate Emergency Contact	Phone	Alternate Phone

DIAGNOSIS OF ASTHMA SEVERITY

☐ Intermittent ☐ Persistent [◯ Mild ◯ Moderate ◯ Severe]

ASTHMA TRIGGERS (Things That Make Asthma Worse)

☐ Smoke ☐ Colds ☐ Exercise ☐ Animals ☐ Dust ☐ Food
☐ Weather ☐ Odors ☐ Pollen ☐ Other ____________

GREEN ZONE: GO!

You have ALL of these:

- Breathing is easy
- No cough or wheeze
- Can work and play
- Can sleep all night

Take These **DAILY CONTROLLER MEDICINES (PREVENTION)** Medicines **EVERY DAY**

☐ No daily controller medicines required
☐ Daily controller medicine(s):____________________
☐ ____________________
Take ______ puff(s) or ______ tablet(s) ______ daily.
☐ For asthma with exercise, ADD: ____________________,
_______ **puffs with spacer** _______ **minutes before exercise**

ALWAYS RINSE YOUR MOUTH AFTER USING YOUR DAILY INHALED MEDICINE.

YELLOW ZONE: CAUTION!

You have ANY of these:

- Cough or mild wheeze
- Tight chest
- Shortness of breath
- Problems sleeping, working, or playing

Continue **DAILY CONTROLLER MEDICINES** and **ADD QUICK-RELIEF** Medicines

Take daily controller medicine if ordered and add this quick-relief medicine when you have breathing problems:

☐ ____________________ inhaler ______ mcg
Take ______ puffs every ______ hours, *if needed.* Always use a spacer, some children may need a mask.
☐ ____________________ nebulizer ______ mg /______ ml
Take a ____________________ nebulizer treatment every ______ hours, *if needed.*
☐ Other ____________________

If quick-relief medicine does not HELP within ______ minutes, take it again and CALL your Health Care Provider

If using quick-relief medicine more than ______ times in ______ hours, CALL your Health Care Provider

IF IN THE YELLOW ZONE MORE THAN 24 HOURS, CALL HEALTH CARE PROVIDER.

RED ZONE: EMERGENCY!

You have ANY of these:

- Very short of breath
- Medicine is not helping
- Breathing is fast and hard
- Nose wide open, ribs showing, can't talk well
- Lips or fingernails are grey or bluish

Continue **DAILY CONTROLLER MEDICINES** and **QUICK-RELIEF** Medicines and **GET HELP!**

☐ ____________________ inhaler ______ mcg
Take ______ puffs every ______ hours, *if needed.* Always use a spacer, some children may need a mask.
☐ ____________________ nebulizer ______ mg /______ ml
Take a ____________________ nebulizer treatment every ______ hours, *if needed.*
☐ Other ____________________

CALL HEALTH CARE PROVIDER AGAIN WHILE GIVING QUICK-RELIEF MEDICINE. If health care provider cannot be contacted, CALL 911 FOR AN AMBULANCE OR GO DIRECTLY TO THE EMERGENCY DEPARTMENT!

REQUIRED PERMISSIONS FOR ALL MEDICATION USE AT SCHOOL

Health Care Provider Permission: I request this plan to be followed as written. This plan is valid for the school year ____________ – ____________ .

Signature ____________________ Date ____________

Parent/Guardian Permission: I give consent for the school nurse to give the medications listed on this plan ~~or trained school staff to assist my child to take them after review by the school nurse. This plan will be shared with school staff who care for my child.~~

Signature ____________________ Date ____________

OPTIONAL PERMISSIONS FOR INDEPENDENT MEDICATION CARRY AND USE AT SCHOOL

Health Care Provider Independent Carry and Use Permission: I attest that this student has demonstrated to me that they can self-administer this rescue medication effectively and may carry and use this medication independently at school with no supervision by school personnel.

Signature ____________________ Date ____________

Parent/Guardian Independent Carry and Use Permission (If Ordered by Provider Above): I agree my child can self-administer this rescue medication effectively and may carry and use this medication independently at school with no supervision by school personnel.

Signature ____________________ Date ____________

COPY FOR PATIENT

AUTHORIZATION FOR ADMINISTRATION OF ASTHMA PRESCRIPTION MEDICATION

RECOMMENDATIONS ARE EFFECTIVE FOR THE CURRENT SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY

Student Name: _____ DOB: _____ Grade: _____
Emergency Contacts: (Name and Phone#'s):_____
_____

I. Parental/Guardian Consent for Administration of Asthma medication

___**I request that my child be ALLOWED to carry and self-administer in school**, his asthma medication listed below pursuant to N.J.S.A. 18A:40-12.3 and 12.4. I give permission for my child to self-administer his/her medication, as prescribed on this form for the current school year. I consider him/her to be responsible and capable of transporting, storing and self-administrating the medication. I understand that the school district, agents and its employees shall incur no liability as a result of any condition or injury arising from the self-administration by the student of the medication prescribed on this form. I indemnify and hold harmless the School District, its agents and employees against any claims arising out of self-administration or lack of administration of this medication by the student.

___**I do not request that my child self-administer his asthma medication.** I request that my child be assisted in taking the medication described below at school by the School Nurse or other individuals authorized to administer medication to students in school pursuant to N.J.A.C:.6A:16-2.3. I understand the ultimate responsibility for administration of the medication is mine, and I am fully aware that the duties of the school nurse and others may require their presence at another location at the time that the medication is needed. I understand that the school district, agents and its employees shall incur no liability as a result of any condition or injury arising from the administration or lack of administration of the medication prescribed on this form. I indemnify and hold harmless the School District, its agents and employees against any claims arising out of administration or lack of administration of this medication.

_____ _____ _____
Parent/Guardian Signature Telephone Date

II. Healthcare Provider Order:

Name of medication: _____

Dosage: _____ Route: _____Frequency:_____

For Student Self Administration:
_____This student has been instructed in and is capable of proper method of self-administration of the medication prescribed above.
_____This student understands the purpose, appropriate method and frequency of use of the medication prescribed above.

____This student is **not** approved to self-medicate

_____
Physician's Name Signature Date

Office Stamp:

This form must be individually completed for **all medications**.
Medications are to be brought to school by the parent in the **original container**, labeled appropriately by the pharmacy.
All medications **will be kept** in a locked storage area.