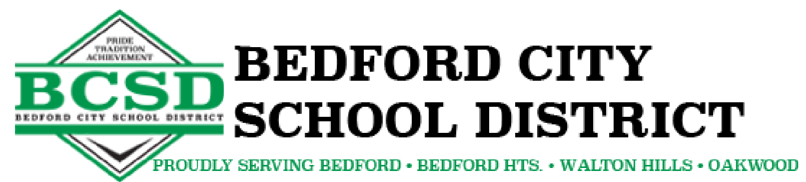

Asthma

Please complete the enclosed Asthma Action Plan and return it to the health office. This form must be completed and signed by your child's healthcare provider EVEN if your child is permitted to self carry their inhaler.

If your child is permitted to self carry and self administer his/her inhaler, please be sure that both pages of the Action Plan are completed and signed. We strongly suggest keeping a second inhaler in the health office in the event your child forgets to bring his or hers to school that day.

If your child is not authorized to self-carry his/her inhaler, please provide one to the health office.

So we may better help your child, please let us know if there are any changes in your child's asthma or medication schedule as soon as the changes occur.

Thank you!

ASTHMA ACTION PLAN

Student's Name	Date of Birth	Effective Dates / / to / /
Health Care Provider	Provider's Phone	
Parent/Guardian	Parent/Guardian Phone	Student Grade//Homeroom:
Emergency Contact	Contact Phone	Additional Emergency contact:

Insert Student Photo Here

Asthma Severity	Asthma Triggers (Things that make your asthma worse)	
☐ Intermittent *or* Persistent: ☐ Mild ☐ Moderate ☐ Severe	☐ Colds ☐ Smoke (tobacco, incense) ☐ Pollen ☐ Dust ☐ Animals:__________ ☐ Strong odors ☐ Mold/moisture ☐ Pests (rodents, cockroaches) ☐ Stress/Emotions ☐Exercise ☐Gastroesophageal reflux ☐ Season (circle):Fall, Winter, Spring, Summer ☐ Other:____	**GREEN means Go!** Use CONTROL medicine daily **YELLOW means Caution!** Add RESCUE medicine **RED means DANGER!** Get help from a doctor now!

Green Zone: Go! — Take these CONTROL (PREVENTION) Medicines EVERY Day

You have **ALL** of these:
- Breathing is easy
- No cough or wheeze
- Can work and play
- Can sleep all night

☐ No control medicines required.

Always rinse mouth after using your daily inhaled medicine.

☐ ______________________________________, ____ puff (s) **MDI with Spacer** __ times a day

☐ ____, ____ nebulizer treatment (s) __ times a day

☐ ______________________________________, take ____ by mouth ___daily at _______

For asthma with exercise, ADD:

☐ ___________________________, _____ puffs _____minutes before exercise

Other Special Instructions:

Yellow Zone: Caution! — Continue CONTROL Medicines and ADD RESCUE Medicines

You have **ANY** of these:
- Cough or mild wheeze
- Tight chest
- Problems sleeping, working, or playing

☐ __________________, ____ puffs with spacer every ____ hours as needed

☐ __________________, ____ nebulizer treatment (s) every ____ hours as needed

☐ Other ____

Other Special Instructions:

Red Zone: DANGER! — Continue CONTROL & RESCUE Medicines and GET HELP!

You have **ANY** of these:
- Can't talk, eat, or walk well
- Medicine is not helping
- Breathing hard and fast
- Blue lips and fingernails
- Tired or lethargic
- Ribs show
- Flared nostrils
- Shortness of breath

☐ _________________, __ puffs **every ___minutes**, for___ treatments

☐ _________________, __ nebulizer treatment **every __ minutes**, for ___ treatments

☐ Other____

Other Special Instructions:

Call 911!

SCHOOL MEDICATION CONSENT AND HEALTH CARE PROVIDER ORDER

CHECK ALL THAT APPLY:

____ **Permission to self carry and administer inhaled medication: Please check here if STUDENT is permitted by Healthcare Provider to self carry and self administer their inhaler at school. (In accordance with ORC 3313.716/3313)**

____ **IF CHILD IS AUTHORIZED TO CARRY/ADMINSTER INHALER, page 2 MUST be completed.**

____ **Student needs supervision or assistance to use his/her inhaler.**

____ **Student should NOT carry his/her inhaler while at school.**

Healthcare Provider SIGNATURE: _________________________ **DATE**__________

OTHER REQUIRED SIGNATURES:

I give permission for school personnel to follow this plan, administer medication and care for my child and contact my provider if necessary. I assume full responsibility for providing the school with prescribed medication and delivery/ monitoring devices. I approve this Asthma Management Plan for my child.

PARENT/GUARDIAN ________________________ **Date** _____

SCHOOL NURSE __________________________ **Date** _____

Authorization for Student Possession and Use of an Asthma Inhaler

In accordance with ORC 3313.716

A completed form MUST be provided to the school health clinic before the student may possess and use an asthma inhaler in school to alleviate asthmatic symptoms, or before exercise to prevent the onset of asthmatic symptoms.

Student name
Student address

This section must be completed and signed by the student's parent or guardian.

As the Parent/Guardian of this student, I authorize my child to possess and use an asthma inhaler, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant.

Parent /Guardian signature	Date
Parent /Guardian name	Parent /Guardian emergency telephone number ( )

This section must be completed and signed by the student's physician.

Name and dosage of medication	
Date medication administration begins	Date medication administration ends (if known)

Procedures for school employees if the medication does not produce the expected relief

Possible severe adverse reactions:

To the student for which it is prescribed (that should be reported to the physician)
To a student for which it is ***not*** prescribed who receives a dose

Special instructions

Physician signature	Date
Physician name	Physician emergency telephone number ( )

Revised March 2021