JOHNSON CREEK
SCHOOL DISTRICT

Photo of child

ASTHMA ACTION PLAN

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 please complete ☐ section)

☐ Give 2 puffs of rescue med *(name)* ☐ ☐ ____ 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 medication)

IF YOU SEE THIS:	**DO THIS:**
- Difficulty breathing - Wheezing - Frequent cough - Complains of chest tightness - Unable to tolerate regular activities but still talking in complete sentences - Other:	- Stop physical activity - Give rescue med *(name)*: _____ 1 puff 2 puffs Via spacer other: _____ -If no improvement in 10-15 minutes, repeat use of rescue med: ☐ 1 puff ☐ 2 puffs ☐ Via spacer ☐ other: _____ -If student's symptoms do not improve or worsen, ☐ ☐ ☐ ☐ call 911 -Stay with student and maintain sitting position -Call parents/guardians and school nurse - Student may resume normal activities once feeling better

- If there is **no rescue medication 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 medication)

IF YOU SEE THIS:	**DO THIS IMMEDIATELY:**
☐ - Coughs constantly - Struggles or gasps for breath	- Give rescue med *(name)*: _____ 1 puff 2 puffs Via spacer Other: _____
- Trouble talking (can speak only 3-5 words) - Skin of chest and/or neck pull in with breathing - Lips or fingernails are gray or blue - ↓ Level of consciousness	Repeat rescue med if student not improving in 10-15 minutes 1 puff 2 puffs Via spacer Other: _____ - Call 911 Inform attendant the reason for the call is asthma - Call parents/guardians and school nurse - Encourage student to take slower deeper breaths - Stay with student and remain calm - *School personnel should not drive student to hospital*

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 Epi-pen® 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.

PARENT SIGNATURE **DATE**

☐ 504 Plan or IEP ☐

School Nurse Signature Date

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

☐ Other: _____