Emergency Action Plan for Asthma

Student Name: ___________________________ **DOB:** __________ **School:** _________________ **Homeroom/Grade** _____________

Parent/Guardian: ____ **Phone:** ____

Emergency Contact: ____ **Phone:** ____

HEALTH CARE PROVIDER COMPLETE ALL ITEMS:

QUICK RELIEF MEDICATION: ☐ Albuterol ☐ Use spacer with inhaler (MDI) ☐ Other:_________________

Student may exhibit the following side effects: Increased heart rate, shakiness, other:________________________________

TRIGGERS: ☐ Weather ☐ Illness ☐ Exercise ☐ Smoke ☐ Dust ☐ Pollen ☐ Poor Air Quality ☐ Other:

☐ Life threatening allergy specify:____

QUICK RELIEF INHALER ADMINISTRATION:

☐ Student needs supervision or assistance to use inhaler. Student will not self-carry inhaler. Location: _________________

☐ Student understands proper use of asthma medications, and in my opinion, can self-carry and use his/her inhaler at school independently with approval from the school nurse and completion of contract.

IF YOU SEE THIS			**DO THIS**
Green Zone: No Symptoms Pretreat		Breathing is good. No cough or wheeze	Use your prescribed maintenance medication daily to keep you in the green zone. 5-15 minutes before exercise, use □ Albuterol _____puffs
Yellow Zone: Mild Symptoms		Wheezing Frequent cough Chest tightness Not able to do activities	Give: Albuterol Inhaler ☐ 2 puffs ☐ 4 puffs ☐ with spacer other ____ If not improving in 15 minutes may repeat: Albuterol Inhaler ☐ 2 puffs ☐ 4 puffs ☐ with spacer other ____ Stay with student and maintain sitting position. Student may go back to normal activities, once symptoms are relieved. Notify parent/guardian. **If symptoms do not improve or worsen, follow RED ZONE.**
Red Zone: Severe Symptoms Emergency		Medicine is not helping. Struggling to breathe Breathing is fast. Nose opens wide. Can't walk. Ribs show when breathing Can't talk well	**CALL 911** Continue to use quick relief medication as ordered until EMS arrives. Stay with student and remain calm. Encourage slow, deep breaths. Notify parent/guardian. Notify the school nurse.

This order remains in effect for the current academic year only and must be renewed each school year. The administration of this medication/treatment to the student during the school day is necessary to maintain and support the student's continued presence in school.

_________________________________ ________ _____________________________________

Health Care Provider Signature **Date** **Phone Number/Office Stamp**

Student Name: _________________________DOB: _________ School: ________________ Homeroom/Grade _____________

PARENT'S PERMISSION

I hereby give my permission for my child _____________________________________ to receive medication/treatment during school hours. This medication/treatment has been ordered and prescribed by a licensed physician. I hereby grant permission for the school nurse to communicate with the prescribing physician about the medication/treatment prescribed. I hereby release the School Board and their agents and employees from all liability that may result from my child taking the prescribed medication/treatment. This consent is good for one year, and may be revoked at any time.

I will furnish all medications for use at school in a container properly labeled by a pharmacist with identifying information, (name of child, medication dispensed, dosage prescribed, the time/frequency it is to be given or taken, the route of administration, the number of doses in the container, and the expiration date of the medication). All over the counter medications will include the order for administration (first part of this authorization form signed by the doctor) with the identifying information, (name of child, medication dispensed, dosage prescribed according to label, and the time it is to be give or taken), with the medication in the original container.

I will replace this medication when it expires. I will remove this medication from the school the last day of school. I understand medication not picked up will be destroyed after the last day of school.

Parent or Guardian Signature: ____

Telephone number(s): ____

Emergency contact number in case you cannot be reached: __________________________________

Student Competence Checklist with Nurse for Self-Administered Medication

□ I have verbalized the name of my medication, informed the nurse of how it is prescribed, and demonstrated competency in using this medication.

□ I will use this medication (and any accompanying equipment) only as directed by my health care practitioner.

□ I will not share my medication with anyone. Sharing medication or using it other than prescribed will result in disciplinary action.

□ I will notify a teacher or staff member if I am having difficulty or need to see the nurse.

□ I will keep my medication with me at all times while in school—location____________________

______________________________ ________________________________ ________________
Signature of Student Signature of Nurse (or trained personnel) Date