# Asthma Action Plan

| Name | Date of Birth | Date / / |
|---|---|---|
| Health Care Provider | Provider's Phone | |
| Parent/Responsible Person | Parent's Phone | School |
| Additional Emergency Contact | Contact Phone | Last 4 Digits of SS# |

**GREEN means Go!** Use CONTROL medicine daily
**YELLOW means Caution!** Add RESCUE medicine
**RED means EMERGENCY!** Get help from a doctor now!

**Asthma Severity** *(see reverse side)*
☐ Intermittent *or*
Persistent: ☐ Mild ☐ Moderate ☐ Severe

**Asthma Control**
☐ Well-controlled ☐ Needs better control

**Asthma Triggers Identified** (Things that make your asthma worse):
☐ Colds ☐ Smoke (tobacco, incense) ☐ Pollen ☐ Dust ☐ Animals________
☐ Strong odors ☐ Mold/moisture ☐ Pests (rodents, cockroaches)
☐ Stress/emotions ☐ Gastroesophageal reflux ☐ Exercise
☐ Season: Fall, Winter, Spring, Summer ☐ Other:____________________

**Date of Last Flu Shot:** ___/___/___

## 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

**Peak flow in this area:**
________ to________
(More than 80% of Personal Best)

**Personal best peak flow:**___________

☐ No control medicines required. **Always rinse mouth after using your daily inhaled medicine.**
☐ ______________________________, ______ puff(s) MDI **with spacer**_____ times a day
Inhaled corticosteroid or inhaled corticosteroid/long-acting β–agonist
☐ ______________________________, _____ nebulizer treatment(s)_____ times a day
Inhaled corticosteroid
☐ ______________________________, take_____ by mouth once daily at bedtime
Leukotriene antagonist
For asthma with exercise, ADD:
☐ __________________, _______ puff(s) MDI with spacer 15 minutes before exercise
Fast-acting inhaled β–agonist
For nasal/environmental allergy, ADD:
☐ ____________________________________________________________

## Yellow Zone: Caution!–Continue CONTROL Medicines and ADD RESCUE Medicines

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

**Peak flow in this area:**
________ to________
(50%-80% of Personal Best)

☐ __________________, ______ puff(s) MDI **with spacer** every ______ hours as needed
Fast-acting inhaled β–agonist
**OR**
☐ __________________, ______ nebulizer treatment(s) every ______ hours as needed
Fast-acting inhaled β–agonist
☐ Other____________________________________________

**Call your DOCTOR if you have these signs more than two times a week, *or* if your rescue medicine doesn't work!**

## Red Zone: EMERGENCY!–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

**Peak flow in this area:**
Less than ________
(Less than 50% of Personal Best)

☐ __________________, ____ puff(s) MDI with spacer **every 15 minutes,** for **THREE** treatments
Fast-acting inhaled β–agonist
**OR**
☐ __________________, ____ nebulizer treatment **every 15 minutes,** for **THREE** treatments
Fast-acting inhaled β–agonist
**Call your doctor while giving the treatments.**
☐ Other____________________________________________

**IF YOU CANNOT CONTACT YOUR DOCTOR: Call 911 for an ambulance or go directly to the Emergency Department!**

**REQUIRED Healthcare Provider Signature:**
__________________________ Date: __________

**REQUIRED Responsible Person Signature:**
__________________________ Date: __________

Follow up with primary doctor in 1 week or:
______________________ Phone:______________
☐ Patient/parent has doctor/clinic number at home

**SCHOOL MEDICATION CONSENT AND PROVIDER ORDER FOR CHILDREN/YOUTH:**
*Possible side effects of rescue medicines (e.g., albuterol) include tachycardia, tremor, and nervousness.*
**Healthcare Provider Initials:**
_____This student is capable and approved to self-administer the medicine(s) named above.
_____This student is not approved to self-medicate.
**As the RESPONSIBLE PERSON:**
☐ I hereby authorize a trained school employee, if available, to administer medication to the student.
☐ I hereby authorize the student to possess and self-administer medication.
☐ I hereby acknowledge that the District and its schools, employees and agents shall be immune from civil liability for acts or omissions under D.C. Law 17-107 except for criminal acts, intentional wrongdoing, gross negligence, or willful misconduct.

Asthma Action Plans must be submitted to the school annually.

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Red Clay Consolidated School District

# Student Permission Form for Possession and Self-Administration of Rescue Inhalers and EpiPens

***(Auto-injectable epinephrine and/or rapid-acting bronchial inhalers ONLY)***

**Student Name:** ________________________________ **School Year:** ________

This letter confirms that the above-named student is a current patient and is being treated for (i.e., health condition): ______________________________________

______________________________________________________________

I agree that the student is responsible and capable of self-administration of the following medications at school (please check those that apply):

_____ **Rapid-acting bronchial inhaler (please include name, dose, and frequency of the medication):** __________________________________

_____ **Auto-injectable epinephrine (please include name, dose, and frequency of the medication):** __________________________________

***The medications must remain in their original container(s) with the prescribing information intact.*

**Healthcare Provider Signature:** _________________________ **Date:** _________

I, the parent/guardian of ______________________, agree that my child is responsible and capable of self-administration of the above medication(s). I accept full responsibility and liability for my child carrying and self-administering this medication(s).

**Parent/Guardian Signature:** ____________________________ **Date:** _________

I, ___________________ (student), agree that I am being given permission by my healthcare provider, my parent/guardian, and my school to carry and take my own above-named medication(s) as needed. I will keep the permitted medication in my book bag/locker. I will not share with or give my medication to anyone. I will not take my medication for any reason except as prescribed. I understand that my parent(s) and I accept full responsibility for my carrying and taking my own medication as prescribed above. I understand that I will lose the privilege of carrying the medication if I misuse it or do not adhere to the above rules.

**Student Signature:** ______________________________ **Date:** ____________

**School Nurse Signature:** ___________________________ **Date:** ____________

***This form must be renewed each school year.***