Student Asthma Action Plan for _____

Physician Name:_____**Physician Phone:**_____

Emergency Plan

Emergency action is necessary when the student has symptoms such as:

- ❑ Tightness in chest — Peak flow reading of _____
- ❑ Increase in Breathing Rate
- ❑ Excessive/increased Cough
- ❑ Chest/Neck pull in with breathing
- ❑ Wheezing

Step 1: If student has any of the above listed symptoms, ***give medications as listed below*** and check peak flow. Follow instructions below.

GREEN ZONE **Good Response**	YELLOW ZONE **Fair Response**	RED ZONE **Poor Response**
***Breathing rate normal** ***Skin color pink** ***Alert and active** ***No chest tightness** ***No cough**	***Breathing rate normal or increasing** ***Mild difficulty breathing** ***Skin color pink** ***Mild cough** ***Mild chest tightness** ***Peak flow _____to_____**	***Breathing rate fast** ***Severe Breathlessness** ***Skin pulling between ribs with each breath** ***Nasal flaring** ***Continual cough** ***Peak flow _____to_____**
⇩	⇩	⇩
Return to Normal Routine	**Call Parent and continue to observe.**	**Get Emergency Treatment!**

Emergency Asthma Medications:

Name	Amount	When to Use
1.		
2.		
3.		
4.		

Daily Asthma Management Plan

- **Identify the things which start an asthma episode (Check each that applies to student.)**

☐ Exercise ☐ Strong odors or fumes ☐ Other_____

☐ Respiratory infections ☐ Chalk dust/ dust

☐ Change in temperature ☐ Carpets in the room

☐ Animals ☐ Pollens

☐ Food_____ ☐ Molds

Comments:_____

See reverse for more instructions *

- **Control of School Environment**

(List any pre-medications, and/or dietary restrictions that the student needs to prevent an asthma episode.)

_____
_____
_____
_____

- **Peak Flow Monitoring**

Personal best peak flow number:_____Monitoring times:_____

Daily Medication Plan

	Name	Amount	When to use
1.			
2.			
3.			
4.			

Comments/Special Instructions

_____

_____

Parent/Guardian Signature** _____Date***_____

FOR INHALED MEDICATIONS-*MUST BE COMPLETED BY PHYSICIAN, STUDENT, AND PARENT IF STUDENT IS ALLOWED TO CARRY INHALER WITH THEM.*

◯ I have instructed this student in the proper way to use his/her inhaler. It is my professional opinion that he/she should be allowed to carry and use the inhaler by him/herself. It is preferable that a second prescription labeled inhaler be kept in the clinic in case the first is lost or left at home.

_____
Physician Signature or Stamp Date

◯ It is my professional opinion that this student should keep an inhaler in the school clinic for use as prescribed.

_____
Physician Signature or Stamp Date

◯ I have been instructed in the proper use of my prescription labeled medication and fully understand how to administer this medication. I will not allow another student to use my medication under any circumstances. I also understand that should another student use my prescription, the privilege of carrying my medication may be revoked. I also accept the responsibility for checking in with the school nurse to keep her informed of use of my medication in case I start having problems.

_____
Student Signature Date

◯ I hereby request that the above named student, over whom I have legal control, be allowed to carry and use the prescription medication described above, at school. I accept legal responsibility should the above medication be lost, given or taken by a person other than the above named student. I understand that if this should happen, the privilege of carrying the medication may be revoked. I release the Camden County School district and its employees of any legal responsibility when the above named student administers his/her own medication.

_____
Parent/Guardian Signature Date