My Asthma **Action Plan**
For Home and School

Name: _____ **DOB:** ____ / ____ / _____

Severity Classification: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Asthma Triggers (list): _____

Peak Flow Meter Personal Best: _____

Green Zone: Doing Well

Symptoms: Breathing is good – No cough or wheeze – Can work and play – Sleeps well at night
Peak Flow Meter _____ (more than 80% of personal best)

Flu Vaccine—Date received: _____ **Next flu vaccine due:** _____ **COVID19 vaccine—Date received:** _____

Control Medicine(s)	Medicine	How much to take	When and how often to take it	Take at
				☐ Home ☐ School
				☐ Home ☐ School

Physical Activity ☐ Use Albuterol/Levalbuterol ____ puffs, 15 minutes before activity ☐ with all activity ☐ when you feel you need it

Yellow Zone: Caution

Symptoms: Some problems breathing – Cough, wheeze, or tight chest – Problems working or playing – Wake at night
Peak Flow Meter _____ to _____ (between 50% and 79% of personal best)

Quick-relief Medicine(s) ☐ Albuterol/Levalbuterol ____ puffs, every 20 minutes for up to 4 hours as needed
Control Medicine(s) ☐ Continue Green Zone medicines
☐ Add _____ ☐ Change to _____

You should feel better within 20-60 minutes of the quick-relief treatment. If you are getting worse or are in the Yellow Zone for more than 24 hours, THEN follow the instructions in the RED ZONE and call the doctor right away!

Red Zone: Get Help Now!

Symptoms: Lots of problems breathing – Cannot work or play – Getting worse instead of better – Medicine is not helping
Peak Flow Meter _____ (less than 50% of personal best)

Take Quick-relief Medicine NOW! ☐ Albuterol/Levalbuterol ____ puffs, _____ (how frequently)

Call 911 immediately if the following danger signs are present:
- Trouble walking/talking due to shortness of breath
- Lips or fingernails are blue
- Still in the red zone after 15 minutes

School Staff: Follow the Yellow and Red Zone instructions for the quick-relief medicines according to asthma symptoms.
The only control medicines to be administered in the school are those listed in the Green Zone with a check mark next to "Take at School".

☐ Both the Healthcare Provider and the Parent/Guardian feel that the child has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

Healthcare Provider
Name _____ Date _____ Phone (____) ____ - _____ Signature _____

Parent/Guardian
☐ I give permission for the medicines listed in the action plan to be administered in school by the nurse or other school staff as appropriate.
☐ I consent to communication between the prescribing health care provider or clinic, the school nurse, the school medical advisor and school-based health clinic providers necessary for asthma management and administration of this medicine.

Name _____ Date _____ Phone (____) ____ - _____ Signature _____

School Nurse
☐ The student has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

Name _____ Date _____ Phone (____) ____ - _____ Signature _____

Preliminary Individualized Healthcare Plan

Name _____ D.O.B. _____

Address _____ Homephone _____

Parents/guardians _____ Grade _____

School _____

Healthcare _____

Provider(s) Insurance _____ ICD-10-CM _____

Provider IEP Date _____ 504 Date _____ EAP Date _____ EEP Date _____

Medical Diagnosis: Asthma/Exercise-Induced Bronchospasm Severity Rating: _____

Nursing Assessment

See the master list in this chapter and *Chapter One: /HP Basics and Using IHPs with Other Educational, Health and Home Care Agency Plans* for additional assessment points.

Review all information provided by parents and health records or orders from current healthcare providers.

Check this student's usual signs/symptoms of an asthma attack or exacerbation:

❏ Difficulty breathing, gasping
❏ Stopping/avoiding activity
❏ Daytime drowsiness/fatigue
❏ Coughing
❏ Nasal flaring
❏ Nighttime wakening or cough
❏ Wheezing
❏ Chest-tightness
❏ Skin in neck and between ribs sinking in with breathing
❏ Blue or grey skin color
❏ Peak flow value <80% of personal best or for age and gender
❏ Shortness of breath
❏ Pallor
Other: _____

Check any known triggers for this student's asthma:

❏ Upper respiratory infections
❏ Environmental tobacco smoke
❏ Damp conditions/molds
❏ Physical activity/exercise
❏ Strong odors/emissions
❏ Foods _____
❏ Cold weather
❏ Grasses/pollen
❏ Medications _____
❏ Poor outdoor air quality
❏ Furry animals/bird feathers
❏ Hard laughing/crying
❏ Poor indoor air quality
❏ House dust mites
❏ Emotional stress or upset
Other: _____

Nursing Diagnoses

❏ Impaired gas exchange related to airway inflammation, bronchoconstriction, and excessive mucus with exercise
❏ Risk of activity intolerance related to exacerbation of symptoms associated with exercise-induced bronchospasm
❏ Anxiety related to experiencing a chronic illness and asthma exacerbations that can be life-threatening
Other: _____

Nursing Interventions

The school nurse will:

❑ monitor availability of prescribed medications and devices to the student on her person and in health office for emergencies, bus, and field trips.

❑ educate student, parent, and appropriate school personnel about expectations for good asthma control and components of student's AAP, including the importance of adherence to therapeutic regimen, proper medication administration, trigger control/avoidance, and actions to take for worsening symptoms.

❑ assess knowledge deficits and learning needs of the student and family related to asthma and its management.

❑ observe for signs of poor coping (e.g., declining academic performance, poor decision-making) and intervene or refer as needed to school's social worker.

Other: _____

Expected Student Outcomes

The student will:

❑ demonstrate good asthma control (e.g., decreased number of days per week with symptoms, fewer night awakenings) and improved participation in school activities within four weeks.

❑ report feeling greater confidence in self-management and improved well-being within 2 weeks.

Other: _____

Plan initiated by _____ Date: _____

MEDICATION/TREATMENT
CONSENT FORM

Student Name _____ Birth Date _____ School Year _____

Diagnosis/Condition _____

CONSENT FOR ADMINISTRATION OF HEALTH TREATMENT AND/OR MEDICATION AT SCHOOL

- Parents are urged to provide health treatments and give medication at home and on a schedule other than school hours if possible. If it is necessary that treatments and/or medication be provided during school hours, these regulations must be followed. *Please Note: "Medication refers to any prescription, non-prescription, homeopathic, herbal, vitamin, or mineral preparation.*
- Health treatments and medications must be prescribed in writing by a physician or other licensed health care provider and must be renewed at least annually. Providers complete Part 1 below and must sign form-Part 2 and fax written instructions to school.
- All medication, prescription and non-prescription, must be brought to school in the original pharmacy container with a current label showing the name of the student, medication, strength, dosage, and time(s) to be given. Only the parent/guardian or other responsible adult or the pharmacy may deliver the medicine to school. Students are not allowed to bring their own medication to school.
- Health treatment supplies will be provided for school use for each student by parent/guardian as needed.
- Parent/guardian written permission is required to administer treatments and medications at school as directed by physician/licensed health care provider, including permission to contact provider as necessary. Parent must sign below-Part 2.

PART I: PHYSICIAN/HEALTH CARE PROVIDER INSTRUCTIONS

TREATMENT/MEDICATION	STRENGTH	DOSAGE/ROUTE	TIME(S)/FREQUENCY	
			Home	School

Recommendations, Special Considerations, Side Effects, Precautions, Allergies: _____

_____

_____

PART 2: AUTHORIZATION SIGNATURES

The following signatures serve as written authorization for permission to administer health treatment and/or medication as directed at school. Authorization includes permission for school personnel and health care provider to contact each other if needed. Medication and Treatment information is kept confidential but it may be shared with appropriate staff for emergency care.

Physician/Provider:

Print Name _____ Signature _____

Date _____ Phone _____ Fax _____

Parent/Guardian:

Print Name _____ Signature _____

Date _____ Phone _____ Fax _____

MEDICATION/TREATMENT
CONSENT FORM FOR SELF-ADMINISTRATION

Student Name _____ Birth Date _____ School Year _____

Diagnosis/Condition _____

CONSENT FOR ADMINISTRATION OF HEALTH TREATMENT AND/OR MEDICATION AT SCHOOL

- Parents are urged to provide health treatments and give medication at home and on a schedule other than school hours if possible. If it is necessary that treatments and/or medication be provided during school hours, these regulations must be followed. *Please Note: "Medication" refers to any prescription, non-prescription, homeopathic, herbal, vitamin, or mineral preparation.*
- Self-administration provisions are for high school students only with the exception of inhalers, epipens and glucagon.
- Health treatments and medications must be prescribed in writing by a physician or other licensed health care provider and must be renewed at least annually. Providers complete Part 1 below and must sign form-Part 2 and fax written instructions to school.
- All medication, prescription and non-prescription, must be brought to school in the original pharmacy container only with a current label showing the name of the student, medication, strength, dosage, and time(s) to be given. Metered dose inhalers must have a label attached to the container.
- Health treatment supplies will be provided for school use for each student by parent/guardian as needed.
- Parent/guardian written permission is required to administer treatments and medications at school as directed by physician/licensed health care provider, including permission to contact provider as necessary. Parent must sign below-Part 2.
- Any misuse of medication by a student, including selling or giving away the medication, that violates school district policy that will result in revocation of self-administration privileges and may result in a referral to law enforcement officials. Please see the student handbook for Waterford School District policies regarding medication at school.

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TREATMENT/MEDICATION	STRENGTH	DOSAGE/ROUTE	TIME(S)/FREQUENCY	
			Home	School

Recommendations, Special Considerations, Side Effects, Precautions, Allergies: _____

PART 2: AUTHORIZATION SIGNATURES

The following signatures serve as written authorization for permission for student to self-administer health treatment and/or medication as directed at school. Authorization includes permission for school personnel and health care provider to contact each other if needed. Medication and Treatment information is kept confidential but it may be shared with appropriate staff for emergency care. *Please Note: School personnel will not supervise the medication administration or have responsibility in the process. Parent will be notified of any observed violation of the above guidelines.*

Physician/Provider:

Print Name _____ Signature _____

Date _____ Phone _____ Fax _____

Parent/Guardian:

Print Name _____ Signature _____

Date _____ Phone _____ Fax _____

Student:

Print Name _____ Signature _____

Date _____ Phone _____ Fax _____