3/2011bmk TODAY'S DATE_____

School Asthma Action Plan

New Haven School District #138

Student: _____DOB:_____Class/Teacher: _____

Parent/Guardian: _____Phone: _____

Address: _____

Healthcare Provider: _____Phone: _____

Healthcare Address: _____Fax: _____

TO BE COMPLETED BY PARENT/GUARDIAN

I, the Parent/Guardian of the student listed above, give permission for the administration of the medications listed below. I also grant NH School permission for the exchange of information with the Healthcare Provider to facilitate my child's asthma and allergy care.

Parent Concerns: _____ Home Phone: _____

_____ Cell Phone: _____

⇨Parent/Guardian Signature: _____ Work Phone: _____

TO BE COMPLETED BY PHYSICIAN/HEALTHCARE PROVIDER

Allergies/Triggers: ☐ None Known ☐ Dust ☐ Pet Dander _____ ☐ Respiratory Infections ☐ Smoke ☐ Mold
☐ Strong Odors ☐ Pollen_____ ☐ Weather Extremes Hot/Cold Temp Above_____F and/or Below_____F ☐ Exercise
☐ Foods_____ ☐ Irritants (e.g. chalk dust) _____ ☐ Emotions _____ ☐ Other_____

School Monitoring & Environment: ☐ Monitor Peak Flow Personal Best _____ Monitoring Time_____ ☐ Do Not Monitor Peak Flow
☐ Administer Medication Before PE ☐ Dietary Restrictions _____ ☐ Environmental Measures _____

GREEN ZONE: *Doing Great!* ☺ No Cough, Wheeze or Difficulty Breathing ☺ Sleeps through night ☺ Can do regular activities

⇨Routine Asthma & Allergy Medication Schedule:

Medicine: _____ Dose: _____ Administration time: _____ Nebulizer or MDI
Medicine: _____ Dose: _____ Administration time: _____ Nebulizer or MDI

YELLOW ZONE: *Caution!!* 😐 Cough 😐 Wheeze 😐 Short of Breath 😐 Can't do usual activities 😐 Loss of appetite

⇨ ① Administer Quick Relief Medication:

Medicine: _____ Dose: _____ Administration Time _____ Nebulizer or MDI
Medicine: _____ Dose: _____ Administration time: _____ Nebulizer or MDI

② Call Parents ③ No improve within 10-20 minutes, repeat treatment & call parent to pick up child ④Condition worsens RED ZONE

RED ZONE: *Danger!!!* ☹ Child has trouble walking/talking ☹ Breathing very fast ☹ Cannot complete sentences
☹ Skin in neck or between ribs pulling in ☹ Braces self to stand ☹ Tri-pod position when sitting ☹ Quick relief medicine not helping

⇨ ① Administer Quick Relief Medication:

Medicine: _____ Dose: _____ Administer Medication IMMEDIATELY! Nebulizer or MDI
Medicine: _____ Dose: _____ Administration time: _____ Nebulizer or MDI

② Call Parents. If unable to reach, call child's Healthcare Provider. ③ CALL 911 if child worsens or does not improve within 5–10 min
④ Other _____

⇨Healthcare Provider Signature: _____ Date _____

FIELD TRIPS & FIELD DAY

Asthma Medication & supplies must accompany student on all Field Trips and Field Days.

SELF ADMINISTRATION OF ASTHMA MEDICATION BY STUDENT

☐ Student has a completed "Self Administration/Self Carry" Asthma Medication form signed & completed on file at school.
☐ Student is NOT allowed to Self-Administer and/or Self Carry Asthma Medication.

FOR SCHOOL USE

☐ Entered into Lumen on _____ ☐ Current Prescription _____ ☐ Medication/Supplies at school _____
☐ Parent present at Asthma Meeting AAP reviewed by: _____ Date _____

Notes: