School Asthma Action Plan

Name	Birth Date	Address
Emergency Contact	Phone	Cell
Triggers	❑ Mold/Pollens ❑ Animals ❑ Colds ❑ Dust ❑ Exercise ❑ Smoke ❑ Weather ❑ Fragrance	

Green Zone: Doing Well

- Breathing is good
- No cough or wheeze
- Can work and play
- Sleeps all night
- No early warning signs
- Peak Flow Meter if used: 80-100% of personal best _____

School Action: Follow actions in marked boxes below for exercise induced asthma

❑ **Medication Before Exercise** ❑ **Medication Before Recess** ❑ **Use routinely every_____ hours**
Medication with spacer: ❑ Albuterol ❑ Ventolin ❑ Proventil ❑ Xopenex
Medication without spacer: ❑ Maxair Autohaler
Dose: puffs **When:** 10-15 minutes before listed activity **Start Date:** School Year **Stop Date:** School Year

Yellow Zone: Getting Worse
(mild trouble breathing)

- Cough, wheeze, chest tight
- Problems working/ playing
- Early warning signs
- Shortness of breath
- Peak Flow Meter if used: 50 to 80% of personal best _____

School Actions: Follow actions in marked boxes below

Take Quick-Relief Medication	How Much (Dose)	When	Start Date	Stop Date
MDI with Spacer: ❑ Albuterol ❑ Ventolin ❑ Proventil ❑ Xopenex **Without spacer:** ❑ Maxair Autohaler	_____ puffs	Student report of symptoms	School Year	School Year
Nebulizer: ❑ Albuterol ❑ Ventolin ❑ Proventil ❑Xopenex	_____ Unit Dose	Student report of symptoms	School Year	School Year

❑ **If symptoms improve after 10-15 minutes: Return to normal activity**
❑ **If symptoms do not improve after 10-15 minutes: Give quick relief medication again and call parents**
❑ **If symptoms improve after the second 10-15 minutes: Return to normal activity and call parents**
❑ **If symptoms do not improve after the medication is repeated: Call EMS (911), School RN and parents**
❑ **If symptoms get worse at anytime: Call EMS (911), School RN and Parents**
❑ **Report frequent use of quick relief medications (twice a day for 3 days, not for exercise) to the School RN and Parents**

Red Zone:
Medical Alert
(severe trouble breathing)

- Cannot stop coughing
- Breathing fast
- Flaring nostrils
- Medication not helping
- Getting worse, instead of better
- Trouble walking or talking from shortness of breath
- The skin between the ribs and above the collarbone pulls in or retracts
- Lips or fingernails are blue

School Actions:
1. **Call EMS (911) IMMEDIATELY**
2. **GIVE QUICK-RELIEVER MEDICATION AND CONTINUE EVERY 15 MINUTES UNTIL EMS (911) ARRIVES**
3. **Call School RN and Parents**

Take Quick-Relief Medications	How Much (Dose)	When	Start Date	Stop Date
MDI with Spacer: ❑ Albuterol ❑ Ventolin ❑ Proventil ❑ Xopenex **Without spacer:** ❑ Maxair Autohaler	_____ puffs	Student report of or observation of symptoms.	School Year	School Year
Nebulizer: ❑ Albuterol ❑ Ventolin ❑ Proventil ❑Xopenex	_____ Unit Dose	Student report of or observation of symptoms	School Year	School Year

Heath Care Provider Name: **Phone:** **FAX#:**

Student Name:_____ **Birth Date:**_____
Address:_____
School Asthma Action Plan (page two)

Metered Dose Inhaler (MDI) Instructions

1. Store at room temperature.
2. Shake the MDI for 5 seconds before each use.
3. Prime the MDI before the first use or when not used every day. Follow the product's patient information sheet for MDI specific priming instructions. Priming usually involves pressing down on the medication canister to discard into the air one or more puff of medication. Discarding puffs makes sure the next puff inhaled contains the labeled amount of medication.
3. Keep track of metered inhalation puffs used. Subtract the number used from the number of metered inhalation puffs available listed on the label. The number of metered inhaled puffs available is listed on the medication canister or on the box. There are usually 200 puffs in an MDI.
4. Ask family for a new MDI when all labeled metered inhalation puffs are used.

MDI and Aerosol Solution Potential Adverse Reaction: Headache, shakiness, fast heart rate, nausea. Call parent with 1) student report of symptoms that interfere with schoolwork or activity 2) increase in side effects 3) frequent usage (2 times a day for 3 days).

We have instructed the patient and family in the proper use of the quick-relief medications. It is my professional opinion that the student:
____ should be allowed to carry and self administer the inhaled medication.

____ should **not** carry and self administer the inhaled medication. The medication should be stored and administered by designated school personnel.

_____ _____
Provider Signature Date

****

Section II To Be Completed by Parent

I give permission for my child to receive medication at school in keeping with Section I above according to the school district policy and as instructed by the physician and agree to 1) Assume responsibility for safe delivery of the medication in its original container to the school, 2) Have a new form completed by the doctor if medication or dosage is changed, 3) Notify the school of changes in health care provider. I release from liability, and in addition agree to indemnify, all school employees, the Board of Education and Akron Children's Hospital School Health Services for damages or injury resulting from the use, misuse or nonuse of such medication except as such Board, School Health Services or its employees are grossly negligent or engage in wanton or reckless misconduct. I further agree to submit a revised statement signed by the physician who has prescribed the medication described in Section I in the event that I become aware that any of the above information has changed. I have read and understand the policy of the School Board for administration of medication and affirm that this request entails special circumstances justifying an exception from the usual administration of medication at school-by-school personnel.

Parent/Guardian Signature: _____ Date: _____

Daytime Phone: _____
THIS FORM EXPIRES AT THE END OF THE SCHOOL YEAR

Akron Children's Hospital

School Health Services
Prescription Medication Administered at School

Attach Student Picture If available

School: _____

School Year: _____

Class/Grade: _____

Student Name: _____ D.O.B.: _____

Student Address: _____

To Be Completed by Physician/Healthcare Provider:

Name of medication: _____ Dose: _____

Time to be given: _____ (during school hours)

Reason for medication: _____

Form of medication: ___ Tablet ___Liquid ___Inhaler ___Nebulizer ___Other

Start Date: _____ Stop Date: _____

Special Instructions: _____

Potential adverse reactions to be reported: _____

_____

Physician/Healthcare Signature: _____ Date: _____

Physician/Healthcare Provider Name: _____
Print Name

Phone: _____ Fax: _____

Parent/Guardian: I give permission for my child to receive this medication at school according to the school district policy and as instructed by my healthcare provider.

I agree and am responsible to:

- **Deliver my child's medicine to school in its original container and labeled by a pharmacist or healthcare provider**
- **Tell the school as soon as possible if there is a change in the use of my child's medicine**
- **Tell the school if my child gets a new healthcare provider**
- **Have my healthcare provider complete a new medicine form for my child if the medicine or dose changes.**

I agree for child's healthcare provider to talk with the school or any school staff person about this medicine. No other part of my child's medical health will be discussed.

Parent/Guardian Signature: _____ **Date:** _____

Parent/Guardian Phone: _____ **Emergency Alternate Phone:** _____

THIS FORM WILL EXPIRE AT THE END OF THE SCHOOL YEAR

Clinic Use Only: Date form received _____ Date medication received: _____ Form Complete (Y or N) _____

Notes: _____ Date Form complete: _____

7/09 4/10 7/12 2/13 11/13 1/14 6/14 6/15 5/18

Akron Children's Hospital

School Health Services

Non-Prescription Medication Administration at School

Attach Student Picture If available

School: _____

School Year: _____

Class/Grade: _____

Student Name: _____ Date of Birth: _____

Student Address: _____

Name of Medication: _____ Dose: _____

Time to be given (during school hours): _____

Reason for Medication to be administered: _____

Form of Medication: _____Tablet _____ Liquid _____ Other

Start date: _____ Stop date: _____

Special Instructions: _____

Potential adverse reactions to be reported to parent or physician: _____

_____

Physician/Healthcare Provider Name: _____ Phone: _____

Parent/Guardian: **I give permission for my child to receive this medication at school according to the school district policy. I agree and am responsible to:**

- **Deliver this medicine to school in its original container.**
- **Tell the school as soon as possible if there is a change in the use of this medicine.**
- **Complete a new medicine form for this medicine if there are dose changes. If medication dosage does not match the instructions on original container, a healthcare provider order is required.**
- **If this medication is needed for greater than 4 consecutive days a healthcare provider order is required.**

I agree for child's healthcare provider to talk with the school or any school staff person about this medication if needed. No other part of my child's medical health will be discussed. When my child receives this medication I will be notified.

Parent/Guardian Signature: _____ **Date:** _____

Parent/Guardian Phone: _____ **Emergency Alternate Phone:** _____

****THIS FORM WILL EXPIRE AT THE END OF THE SCHOOL YEAR****

Clinic Use Only: Date form received _____ Date medication received: _____ Form Complete (Y or N) _____

Notes: _____ Date Form complete: _____