Asthma Action Plan

Please Attach to Authorization for Medication Form

☐ Castlemont Primary Academy
☐ Castlemont Junior Academy

Student's Name: _____ Date of Birth: _____

Grade: _____ Teacher: _____ Room: _____

Parent/Guardian Name: _____ Parent/Guardian Phone: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Healthcare Provider Name: _____ Healthcare Provider Phone: _____

TO BE COMPLETED BY LICENSED PHYSICIAN

Asthma triggered by: ☐ Exercise ☐ Cold Air ☐ Animal Dander ☐ Strong Odors ☐ Grass/Pollen ☐ Cold/Flu ☐ Mold ☐ Other

Controller Medicine at Home	How Much to Take	How Often	Other Instructions
		_____ time(s) per day everyday	

I am doing well (Green Zone)	Prevent asthma symptoms everyday:
• Breathing is good, and • No cough, wheeze, chest tightness, shortness of breath (day or night • Can work or play as normal • Peak flow (ages 5 and up) _____ to _____ (80-100% of personal best)	☐ Take controller medicine everyday at home as prescribed ☐ Before exercise, take _____ puff(s) of _____ with space (if available 10 minutes before exercise **Personal Best Peak Flow is** _____
I am getting worse (Yellow Zone)	**CAUTION, continue taking everyday controller medicine at home AND**
• Cough, wheeze, chest tightness, shortness of breath, can do some but not all usual activities • Waking at night due to asthma • Peak flow (ages 5 and up) _____ to _____ (50-79% of personal best) **If NOT in Green Zone after the 2nd dose of medicine, GO TO THE RED ZONE**	Begin QUICK RELIEF medication right NOW • Take _____ puffs of _____ with spacer (if available) • Wait 15-20 minutes. If symptoms are not better, repeat the above dose and wait another 15 minutes • If symptoms return to GREEN ZONE, wait 15 minutes • If symptoms remain in the green zone, return to class and continue using quick relief medicine _____ puffs every _____ hours as needed
Medical Alert (Red Zone)	**EMERGENCY! Get Help! Do Not Leave Student Alone!**
• Severe chest tightness, very short of breath, uncontrolled cough • Nose opens wide or ribs show with breath, or • Quick relief medicine has not helped, or • Trouble talking or walking, or • Blue lips or fingernails, or drowsy or confused • Peak flow (ages 5 and up) _____ to _____ (49% of personal best)	• Take ☐4 or ☐6 puffs of _____ with spacer (if available) • Repeat every 10-15 minutes until paramedics arrive • **Call 911 immediately and call parent/guardian**

Health Care Provider

My signature provides authorization for the above written order. I understand that all procedures will be implemented in accordance with state laws and regulations. **Student may carry and self-administer asthma medication:** ☐ Yes ☐ No

Print Provider Name/Credentials: _____ Signature _____ Date _____

Parent/Guardian Request and Authorization

I request that the **school assist my child with the above asthma medication(s) and Asthma Action Plan** as ordered by the health care provider in accordance with state laws and regulations. I understand that the medication must have a pharmacy label with the name of the student and the health care provider. I give permission for the school staff to communicate with the healthcare provider on matters related to this Asthma Action Plan:

The school will carry and assist my child with the administration of asthma medication ☐ Yes ☐ No
My child may carry and self-administer asthma medications: ☐ Yes ☐ No

Print Parent Name: _____ Signature _____ Date _____