DAYTON PUBLIC SCHOOLS

# SCHOOL ASTHMA ACTION PLAN

| Student Name: | | D.O.B: | Student ID #: |
|---|---|---|---|
| School: | | | Grade: |
| Student's Address: | | | |
| Parent/Guardian: | Home: | Cell: | Work: |
| Other Emergency Contact: | Home: | Cell: | Work: |
| Allergies to Medication(s): | | | |

| **Asthma Severity:** (Please circle response) Intermittent or Persistent Mild Moderate Severe | **Asthma Triggers Identified** (Please circle response) Exercise Colds Smoke (tobacco, fires, incense) Pollen Dust Animals Strong Odors Mold moisture Stress/Emotions Pests Gastroesophogeal Reflux Seasons: Fall Winter Spring Summer Other: ________________ | **Date of Last Flu Shot:** ___/___/__ | **Inhailer is kept:** ☐ With Student ☐ In Classroom ☐ In School Clinic ☐ Other: _________ |
|---|---|---|---|

**Health Care Provider: Please complete the following information for all zones:**

| **Green Zone: GO! Take Control Medications EVERY DAY** | |
|---|---|
| **You have ALL of these:**<br>• **Breathing is easy**<br>• **No cough or wheeze**<br>• **Can work and play**<br>• **No symptoms at night**<br>**Peak flow (optional):**<br>**Greater than ≥ _______________**<br>**(More than 80% of Personal Best)**<br>**Personal best peak flow: _______** | No control medicine required **Always rinse mouth after using your daily inhaled medicine**<br>___________________________, ______ puff(s) MDI with spacer ______ times a day.<br>___________________________, ______ nebulizer treatment(s) ______ times a day.<br>___________________________, ______ take ______ by mouth once daily at bedtime.<br>Exercise Modifications:<br>For asthma with exercise, ADD:<br>___________________________, ______ puff(s) MDI with spacer 15 minutes before exercise<br>For nasal/environmental allergy, ADD:<br>____________________________________________________________________________________ |
| **Yellow Zone: Caution! Continue CONTROL Medicine & ADD RESCUE Medicines** | |
| **You have ANY of these:**<br>• **Cough or mild wheeze**<br>• **Tight chest**<br>• **First signs of a cold**<br>• **Problems sleeping, playing, or working**<br>**Peak flow (optional):**<br>**________ to ________**<br>**(50% - 80% of Personal Best)** | **DO NOT LEAVE STUDENT ALONE! Call Parent/Guardian when rescue med is administered.**<br>___________________________, ______ puff(s) MDI with spacer & every ____ hour as needed.<br>___________________________, ______ nebulizer treatment(s) & every ____ hour(s) as needed.<br>Other ______________________________________________________________________________<br>Call your MEDICAL PROVIDER if you have these signs more than two times a week, or if your rescue medicine does not work! If symptoms are NOT better OR peak flow is NOT improved, go to **RED ZONE**. |
| **Red Zone: EMERGENCY! Continue CONTROL Medicine & ADD RESCUE Medicines and GET HELP!** | |
| **You have ANY of these:**<br>• **Cannot talk, eat, or walk well**<br>• **Medicine is not helping**<br>• **Getting worse, not better**<br>• **Breathing hard and fast**<br>• **Blue lips & fingernails**<br>**Peak flow (optional):**<br>**Less than ≤ _________________**<br>**(Less than 50% of Personal Best)** | **DO NOT LEAVE STUDENT ALONE!** **Call for emergency 911 and start treatment**<br>__________________________, ______ puff(s) MDI with spacer & every 20 minutes until paramedics arrive<br>__________________________, ______ nebulizer treatment(s) & every 20 minutes until paramedics arrive<br>**Call 911 immediately and call Parent/Guardian**<br>Other: _____________________________________________________________________________ |

| Possible adverse reactions that should be reported to provider: | | Possible adverse reaction to child for whom medication is NOT prescribed: |
|---|---|---|
| Plan Start Date: | Plan End Date: | Special Instructions: |
| Provider Phone: | Provider Fax: | Provider Address: |

**HEALTH CARE PROVIDER ORDER AND SCHOOL MEDICATION CONSENT**

*Check all that apply:*

____ Student has been instructed in the proper use of his/her asthma medications and is able to carry and self-administer his/her inhaler at school.
____ Student is to notify designated school health personnel after using inhaler at school.
____ Student needs supervision or assistance when using inhaler.
____ Student should not carry his/her inhaler while at school.

Signature/Title: ____________________________________________________________

Date: _____________________________________________________________________

**Parent/Guardian:**

I approve of this asthma action plan. I give my permission for the school nurse and trained school personnel to follow this plan, administer medication(s), and contact my provider, if necessary. I assume full responsibility for providing the school with the prescribed medications and delivery and monitoring devices. I give my permission for the school to share the above information with school staff that need to know and permission for my child to participate in any asthma educational learning opportunities at school.

Signature: _________________________________ Date: ______

School Nurse: ______________________________ Date: ______

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