Stewartville School District #534

Asthma Action Plan

(insert picture)

Date of Plan: / / This plan is valid for the current year: 20_____

STUDENT INFORMATION

Name: _____ DOB: ____/ ____/ ____ Grade: _____ School: _____

What triggers my asthma?

_____

Always use a (circle choices)**: holding chamber/spacer with/without a mask** with your inhaler.

GREEN ZONE	DOING WELL	GO!
You have ALL of these: * Breathing is good * No coughing or wheezing * Can work/play easily * Sleeping all night	**1:** Take these controller medicines every day: MEDICINE / HOW MUCH / WHEN _____ _____ _____	
	2: If exercise triggers your asthma, take the following medicine(s) 15 minutes before exercise or sports. MEDICINE / HOW MUCH / WHEN _____ _____	
	3: Other instructions: _____ _____	

YELLOW ZONE	GETTING WORSE	CAUTION!
You have ANY of these: * It's hard to breathe * Coughing * Wheezing * Tightness in chest * Cannot work/play easily * Wake at night coughing	**1:** Keep taking **GREEN ZONE** medications	
	2: Take the following quick-relief medications: MEDICINE / HOW MUCH / WHEN _____ _____ _____	
	3: If you are in the **YELLOW ZONE more than 6 hours,** or your symptoms are **getting worse,** follow **RED ZONE instructions.**	

RED ZONE	EMERGENCY	GET HELP NOW!
You have ANY of these: * It's very hard to breathe * Nostrils open wide * Ribs are showing * Medicine is not helping * Trouble walking or talking * Lips or fingernails are grey or bluish	**1:** Take your quick-relief medicine **NOW:** MEDICINE / HOW MUCH _____ or 1 *nebulizer treatment* of _____ **AND**	
	2: Call your health care provider **NOW** **AND** Go to the emergency room or **OR CALL 911** immediately.	

PHYSICIAN AUTHORIZATION OF ADMINISTRATION OR SELF CARRY

_____ This Asthma Action Plan provides authorization for the administration of medicine described in the AAP.

_____ This child has the knowledge and skills to self-administer quick-relief medicine at school with approval of the school nurse.

DATE: _____ / _____ / _____ MD/NP/PA SIGNATURE: _____

This consent may supplement the schools consent to give medicine and allows my child's medicine to be given at school.
My child (circle one) **may / may not** carry, self-administer and use quick-relief medicine at school with approval from the school nurse (if applicable).

DATE: _____ / _____ / _____ PARENT/GUARDIAN SIGNATURE: _____