REED-CUSTER Asthma Action Plan

Student: ______________________ **DOB:** ____________ **School Year:** ____________

School (circle one): RCES RCMS RCHS **Grade:** ______ **Teacher:** ____________

Parent/Guardian & Phone(s): ____

Physician & Phone: ____

KNOWN ALLERGIES: ____

Dear Parent/Guardian:
An Asthma Action Plan is needed on all asthmatic students. The following plan will provide instructions according to the symptoms found. It allows one to begin treatment early to prevent a full-blown asthma episode. It will also assist with medication choices according to symptoms and peak flow numbers. Have the doctor fill out the following:

Asthma Triggers	

Follow the attached physician action plan; if no plan submitted, call 911 and parent/guardian.

Level	Symptoms (Sx)	Peak Flow	Medication Orders
Green (Good control)	• Normal breathing • No cough or wheeze • Normal activity & sleep • Avoid triggers	80-100% personal best: ________	
Yellow (Caution)	• Symptoms occur with activity • Symptoms subside with reliever • Reliever used 4x's/day • Cold symptoms • Increase meds @ 1st sign	60-80% personal best: ________	Reliever every 4 hours. If no improvement in a few days, see the doctor.
Red (Danger) **Call 911**	• Difficulty breathing • Wheeze @ rest • Difficult to walk or talk • Lips/fingernails are blue or grey • Reliever does not help in 10 minutes or less than 3 hours • Skin sucked in @ neck, between ribs, or around collarbone with each breath	≤ 60% personal best: ________	Use reliever meds as much as needed on the way to hospital.

Physician's Signature: ______________________________ **DATE:** ____________

☐ Asthma Action Plan is no longer needed. Explanation: ______________________________

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If medications must be given during school hours, an **Authorization for Medication** form must be completed every school year. It must be filled out and signed by you and your physician. Medications used in school must be in the original container. When you have a prescription filled, ask the pharmacist for two containers; one for school and one for home use. If your student participates in field trips and needs medication during that time, a separate container may be necessary for that day as well.

Parental approval of student Health Care Plan:

PARENT/GUARDIAN SIGNATURE: ______________________________ **DATE:** ____________

REED-CUSTER Asthma Action Plan

Student: ______________________ **DOB:** __________ **School Year:** ______________
School (circle one): RCPS RCIS RCMS RCHS **Grade:** ____ **Teacher:** ______________
Parent/Guardian & Phone(s): ____
Physician & Phone: ____
KNOWN ALLERGIES: ____

Doctor's letter is required if activity is limited

Be specific: ____

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Please answer the following questions:

My health care provider provided training.	☐No	☐Yes
My child knows his/her *Asthma Triggers*.	☐No	☐Yes
My child understands *Peak Flow Monitoring*.	☐No	☐Yes
My child understands the proper use of his/her inhalers/relievers.	☐No	☐Yes
The doctor has provided an *Asthma Action Plan*.	☐No	☐Yes
I have provided the school district with the required *Asthma Action Plan*.	☐No	☐Yes
Questions remain, and I will follow-up with my own health care professional to obtain the required *Asthma Action Plan*.	☐No	☐Yes
Student or parent is interested in an *Asthma Training Session* with the School Nurse.	☐No	☐Yes

CONSENT

Please circle your response and sign: (I do / I do not) give the School Nurse my permission to share information relevant to my child's medical status with school staff on a "need to know" basis, if she/he determines that this information is necessary to assure my child's health and safety.

PARENT/GUARDIAN SIGNATURE: ______________________ **DATE:** ______________