Student Photo

Asthma Action Plan

Student's Name:	Date of Birth:
Contact Teacher:	School/Grade:
Parent/Guardian Name:	Phone (Family):
Address:	
Emergency Number:	Relationship:
Asthma Specialist:	Office Phone:
Family Physician:	Office Phone:

Please indicate (circle one): with / without spacer Pulse oximeter range: _____

_____ has demonstrated proper use and inhaler technique and should be allowed to carry and use
(Student name) his/her asthma inhaler(s) by himself/herself.

_____ will need assistance with his/her asthma inhaler(s) and should be kept by the school teacher or
(Student name) personnel but must be given immediately for asthma symptoms.

☐ Keep the prescribed emergency inhaler in his/her possession

☐ Self - administer the prescribed inhaler as permitted by law
** If not checked. Inhaler will be kept in clinic and medication trained staff will assist student with inhaler as needed**

GREEN ZONE: I AM MEETING MY ASTHMA GOALS

THE GREEN ZONE SHOULD BE YOUR GOAL EVERY DAY.

Symptoms:
- No coughing, shortness of breath, wheezing, or chest tightness
- Sleeping all night
- Can do all usual activities (work, play)

AND

Peak Flow Meter (If used):
My peak flow today is _____,
which is 80% or more of my personal best peak flow.

Action Plan:
- Avoid triggers or things that make my asthma worse like: _____
- Continue to take my asthma medicine as directed by my doctor

MEDICINE(S):	HOW MUCH:	WHEN:

Before exercise:

MEDICINE:	HOW MUCH:	WHEN:

YELLOW ZONE: CAUTION, MY ASTHMA SYMPTOMS ARE GETTING WORSE

Symptoms:
- Some problems with coughing, shortness of breath, wheezing, or chest tightness OR
- Waking up at night due to asthma OR
- Using more quick-relief asthma medicine OR
- Can do some, but not all, usual activities (work, play)

OR

Peak Flow Meter (If used):
My peak flow today is _____,
which is between 50% and 79% of my personal best peak flow.

Action Plan:
- Keep taking my asthma medicine as directed by my doctor, including my quick-relief medicine
- Continue monitoring my symptoms/peak flow
- See my doctor regularly

MEDICINE(S): **HOW MUCH:** **WHEN:**

RED ZONE: I AM HAVING SERIOUS SYMPTOMS. I NEED TO CALL MY DOCTOR OR CALL 911 NOW!

Symptoms:
- Symptoms are same or worse after 24 hours in the Yellow Zone OR
- Very short of breath OR
- Quick-relief asthma medicines have not helped OR
- Cannot do usual activities (work, play)

OR

Peak Flow Meter (If used):
My peak flow today is _____,
which is less than 50% of my personal best peak flow.

Action Plan:
- **CONTACT A DOCTOR IMMEDIATELY**
- Take my quick-relief asthma medicine as directed by my doctor

MEDICINE(S):	HOW MUCH:	WHEN:

CALL 911 IF YOU ARE IN THE RED ZONE AND HAVING DANGER SIGNS SUCH AS:
- Trouble walking or talking due to shortness of breath
- Lips or fingernails are blue

This plan is subject to change, but only with documentation from physician along with meeting with parents and staff. This plan will be shared with all teachers, support staff, and transportation staff who are involved with student's school day.

I am in agreement with this plan of care and understand it will be shared as needed with members of the school staff to safeguard and promote the health of the student listed above while at school. I will notify the school immediately: 1) if the health status of the student listed above changes, 2) we change physicians, or 3) there is a change or cancellation of the physician's orders.

Parent/Legal Guardian _____
Date _____

Registered Nurse _____
Date _____

MEDICAL REVIEW

I have reviewed the Asthma Action Plan (AAP) for _____, and:

_____ I approve the AAP as written.

_____ I approve the AAP with the attached amendments.

_____ I do not approve of the AAP as written, and substitute orders are attached.

Physician_____
Date _____

Other Recommendations: _____

_____

_____

_____

_____

Copies to:

☐ Board Office ☐ Bus Garage ☐ Teacher ☐ Other

Ohio Department of Health

Authorization for Student Possession and Use of an Asthma Inhaler

In accordance with ORC 3313.716/3313.14

A completed form must be provided to the school principal and/or nurse before the student may possess and use an asthma inhaler in school to alleviate asthmatic symptoms, or before exercise to prevent the onset of asthmatic symptoms.

Student name
Student address

This section must be completed and signed by the student's parent or guardian.

As the Parent/Guardian of this student, I authorize my child to possess and use an asthma inhaler, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant.

Parent /Guardian signature	Date
Parent/Guardian name	Parent/Guardian emergency telephone number ( )

This section must be completed and signed by the student's physician.

Name and dosage of medication	
Date medication administration begins	Date medication administration ends (if known)

Procedures for school employees if the medication does not produce the expected relief

Possible severe adverse reactions:

To the student for which it is prescribed (that should be reported to the physician)
To a student for which it is ***not*** prescribed who receives a dose

Special instructions

Physician signature	Date
Physician name	Physician emergency telephone number ( )

Adapted from the Ohio Association of School Nurses