ASTHMA ACTION PLAN

Dear Parent/Guardian:

You have indicated that your child has asthma.Please complete the attached **ASTHMA ACTION PLAN** and return the plan as soon as possible to the school clinic. The plan must be completed in its entirety and signed by both you **AND** your child's physician. The information will only be shared with the appropriate personnel such as your child's classroom teacher(s) and physical education teacher. This information that you and your medical provider provide will help to support the health and safety of your child.

If your student:

- Requires medication at school to be administered by school staff, please have an adult bring it to your student's school in the original container provided by the pharmacist, along with the completed paperwork..
- Requires medication **AND** is permitted to self-carry (and all of the forms have been completed and provided to the school clinic), please provide a back-up inhaler for your student in the event he/she requires treatment but does not have medication available.
- Is no longer under the care of a physician for asthma, please handwrite a note and forward it to the school clinic as soon as possible. This will allow us to remove the medical alert from your child's record.
- When completing the asthma action plan for incoming kindergarten students, please do not complete the plan prior to the end of the current school year.
- A medication administration form does not need to be completed with the asthma action plan.

Please inform the school's clinic of any changes in your child's health condition or medication schedule should a change arise during the school year. If you have any questions, please contact me.

Sincerely,

Jenni Rusin RN
Rocky River City Schools
440-356-6720

Rocky River City School District

ASTHMA ACTION PLAN for SCHOOL

University Hospitals Rainbow Babies & Children's

Student Photo

Student_____ DOB_____

School_____ Grade/Rm_____

PARENT/GUARDIAN EMERGENCY CONTACT INORMATION:

Parent/Guardian-1 (name/relationship):_____ Phone:_____

Parent/Guardian-2 (name/relationship):_____ Phone:_____

Asthma Triggers_____ Spacer: _____YES_____NO

Does the student use an Epi-pen: YES / NO

Green Zone: Doing Well

Symptoms: Breathing is good, no cough or wheeze, can play and run

MEDICINE	DOSE	WHEN AND HOW OFTEN TO TAKE IT
FOR ASTHMA WITH EXERCISE, TAKE:		

Yellow Zone: Caution. Child exhibiting some problems breathing

Symptoms: Cough, mild wheeze, tight chest, shortness of breath, problems playing, exposure to known trigger

MEDICINE	DOSE	WHEN AND HOW OFTEN TO TAKE IT

☐ Can repeat dose every 4 hours as needed. If symptoms unresolved or getting worse, follow **red zone**, seek medical attention and contact the parent.

Red Zone: Emergency Quick-relief medicine has not helped

Symptoms: very short of breath, trouble talking/walking, nasal flaring, use of accessory muscles, blue or gray discoloration of the lips or fingernails. Obtain medical attention right away!

MEDICINE	DOSE
	Number of puffs_____
	Can repeat every_____ minutes up to _____ times

FOLLOW THE YELLOW AND RED ZONE INSTRUCTIONS FOR RESCUE MEDICATION ACCORDING TO THE STUDENT'S SYMPTOMS.

Healthcare Provider: (circle correct response)

YES / NO: Student is PERMITTED to CARRY an inhaler and SELF-MEDICATE at school with the understanding that he/she is to report to the school clinic if symptoms do not improve.

Signature of Prescriber_____ Date_____

Signature of Parent/Guardian_____ Date_____