

# John Adams Academy: ASTHMA ACTION PLAN

**PLEASE NOTE: A new form is required for each school year.**

**STUDENT INFORMATION:**

Student Name (Last, First): \_\_\_\_\_ Birthdate: \_\_\_\_\_

School: \_\_\_\_\_ Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_

**TRIGGERS:**     Dust   Exercise   Illness   Molds   Pollen   Weather   Smoke   Animals   Emotions (e.g. when upset)

Foods: \_\_\_\_\_ Other: \_\_\_\_\_ Life Threatening allergy, specify: \_\_\_\_\_

**HEALTHCARE PROVIDER TO COMPLETE ALL ITEMS BELOW: (PLEASE SIGN AND DATE BELOW)**

**QUICK RELIEF (RESCUE) MEDICATION:** \_\_\_\_\_ Have scholar use SPACER

**COMMON SIDE EFFECTS:** \_\_\_\_\_

**CONTROLLER MEDICATION (Used at home):** \_\_\_\_\_

<b>Green Zone:</b> No symptoms Pretreat	<ul style="list-style-type: none"> <li>No current symptoms</li> <li>Doing usual activities</li> </ul>	Pretreat before exercise: <input type="checkbox"/> Not required <input type="checkbox"/> Routine <input type="checkbox"/> Parent/scholar requested Give QUICK RELIEF MED 10-15 minutes before activity: <input type="checkbox"/> 2 puffs <input type="checkbox"/> 4 puffs <input type="checkbox"/> Repeat in 4 hours, if needed for additional activity.
<b>Yellow Zone:</b> Mild symptoms	<ul style="list-style-type: none"> <li>Trouble breathing</li> <li>Wheezing</li> <li>Frequent cough</li> <li>Not able to do activities, but talking in complete sentences</li> </ul>	1. Stop physical activity. 2. Give QUICK RELIEF MED: <input type="checkbox"/> 2 puffs <input type="checkbox"/> 4 puffs 3. Stay with scholar and maintain sitting position. 4. <b>REPEAT</b> QUICK RELIEF MED if not improving in 15 minutes: <input type="checkbox"/> 2 puffs <input type="checkbox"/> 4 puffs 5. Notify parent/guardian and school nurse. 6. Child may return to normal activities once symptoms are relieved, <b>OR</b> <b><i>If symptoms do not improve or worsen, follow RED ZONE</i></b>
<b>Red Zone</b> <b>EMERGENCY</b> Severe symptoms	<ul style="list-style-type: none"> <li>Coughs constantly</li> <li>Struggles to breathe</li> <li>Trouble talking (only speaks 3-4 words)</li> <li>Skin of chest and/or neck pull in with breathing</li> <li>Lips/nails gray or blue</li> <li>Decreased level of consciousness</li> </ul>	1. Give QUICK RELIEF MED: <input type="checkbox"/> 2 puffs <input type="checkbox"/> 4 puffs 2. Refer to anaphylaxis plan, if child has life-threatening allergy. 3. <b>Call 911</b> 4. Stay with child. Remain calm. Encourage slower, deeper breaths. 5. Notify parent/guardian and school nurse. 6. If symptoms do not improve, <b>REPEAT</b> QUICK RELIEF MED: <input type="checkbox"/> 2 puffs <input type="checkbox"/> 4 puffs (every 5 minutes until EMS arrives)

**PROVIDER INSTRUCTIONS FOR QUICK RELIEF INHALER USE: CHECK APPROPRIATE BOX(ES):**

- Student needs supervision or assistance to use inhaler. Student will NOT self-carry inhaler. Medication in health office.
- Student understands proper use of asthma medications, and can carry and self-administer inhaler at school with approval from school nurse.
- Student will notify school staff after using quick relief inhaler, if symptoms do not improve with use.  
*As the prescribing physician in the event there is no school nurse, or other licensed person to administer medication, I authorize a trained unlicensed assistive person/trained health care aid to administer this prescribed medication to the above student.*

\_\_\_\_\_ STAMP:

HEALTH CARE PROVIDER SIGNATURE

DATE

PRINT PROVIDER NAME

PHONE

**PARENT/GUARDIAN TO COMPLETE BACK OF FORM**

## ASTHMA HISTORY

When was the Scholar's asthma first diagnosed? \_\_\_\_\_

Has the Scholar visited the ER for asthma related symptoms in the last year? \_\_\_\_\_

Has the Scholar ever been hospitalized for asthma? \_\_\_\_\_

Admitted to the ICU for asthma? \_\_\_\_\_

If so, when? \_\_\_\_\_

How many days of school were missed for asthma related symptoms last school year? \_\_\_\_\_

What medications are taken at home for asthma:

Medication: _____	Dose/frequency: _____
Medication: _____	Dose/frequency: _____
Medication: _____	Dose/frequency: _____

What other non-pharmacological treatments are used at home for asthma: (circle all that may apply, and expand if necessary)

Breathing exercises \_\_\_\_\_ Relaxation \_\_\_\_\_

Drinking liquids \_\_\_\_\_ Herbal remedies \_\_\_\_\_

Other \_\_\_\_\_

Has your child received asthma education? \_\_\_\_\_

Would you like more information on asthma? \_\_\_\_\_

The parent/guardian of the above named student, request that this Asthma Action Plan be used to guide asthma care for my child. I agree to:

1. Provide necessary supplies and equipment
2. Notify the school nurse of any changes in the student's health status
3. Notify the school nurse and complete a new consent for any changes in medication orders

**I ACKNOWLEDGE IF MY STUDENT CARRIES AND ADMINISTERS HIS/HER OWN INHALER, IT MUST BE WITH THEM IN ORDER TO ATTEND A FIELD TRIP.**

*In agreeing to have the school administer my child's medication, I voluntarily agree to release, discharge and hold harmless John Adams Academy and its officers, agents and employees for any and all claims of liability arising out of their negligence, recklessness or any other act of omission which cause my child's illness, injury, death, and damages of any nature in any way connected with the administration of medication. I acknowledge and understand the medication may be administered by a school nurse or by designated school personnel, and will only be delivered consistent with Policy. I understand that I may terminate the consent for the administration of medication or for otherwise assisting the student in the administration of medication by providing written notice to John Adams Academy. **I authorize the school to communicate with the physician listed above regarding my child's medical condition and/or medication prescribed for it.***

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent/Guardian Name (Print): \_\_\_\_\_

Phone: \_\_\_\_\_

School Nurse Signature:

Date: