ASTHMA ACTION CARD

Name _____ **Birthdate** _____ **Teacher** _____

School Nurse _____ **Phone** _____ **Fax** _____

Healthcare Provider treating student for Asthma _____ **Phone** _____

Preferred Hospital_____ **Personal Best Peak Flow Reading** _____

Green Zone: All Clear

- **Breathing is easy. No asthma symptoms with activity or rest.**
- **Peak Flow Range: _____ to _____ (80%-100% of personal best) *If applicable.***

☐ **Pre-medicate if needed 10-20 minutes before sports, exercise or other strenuous activity.**

☐ **Pre-exercise medications listed in #1 below.**

Yellow Zone: Caution

- **Cough or wheeze. Chest is tight. Short of breath.**
- **Peak Flow Range: _____ to _____ (50%-80% of personal best) *If applicable.***
- **Medicate with quick reliever. Give medications as listed below.**
- **May re-check peak flow in 15-20 minutes.**
- **Student should respond to treatment in 15-20 minutes and return to Green Zone, if not, contact parent.**

Red Zone: Emergency Plan

- **Call EM-911 if student has any of the following:**
  - ✓ **Coughs constantly**
  - ✓ **No improvement 15-20 minutes after initial treatment with medication**
  - ✓ **Hard time breathing with some or all of these symptoms of respiratory distress:**
    - ☐ **Chest and neck pulled in with breathing**
    - ☐ **Stooped body posture**
    - ☐ **Struggling or gasping**
  - ✓ **Trouble with waling or talking due to shortness of breath**
  - ✓ **Lips or fingernails are grey or blue**
  - ✓ **Peak flow below _____ (50% of personal best) *If applicable*.**
- **Medicate with quick reliever. Give medications as listed below.**
- **Re-check Peak Flow in 15-20 minutes.**
- **Student should respond to treatment in 15-20 minutes.**
- **Contact parent or guardian.**

EMERGENCY ASTHMA MEDICATIONS—*To be completed by Healthcare Provider*

1. **Med** _____ **Dose** _____
2. **Med** _____ **Dose** _____

Authorization by Healthcare Provider:

☐ **This child has received instruction in the proper use of his/her asthma medications.**

☐ **It is my professional opinion that this student should/should not (Circle One) be allowed to carry, store, and use his/her asthma medications by him/herself.**

***Healthcare Provider Signature*: _____ Date _____**

Created by Asthma and Allergy Foundation of America, Alaska Chapter and the Alaska Asthma Coalition, October 2005.

ASTHMA ACTION CARD

DAILY ASTHMA MANAGEMENT PLAN ***Side 2, Continued:*** **TO BE COMPLETED BY PARENT/GUARDIAN AND STUDENT**

Student Name: _____ Birthdate _____

- **Identify the things which start an asthma episode (if known) Check all that apply. These should be excluded from the student's environment as much as possible.**

☐	**Exercise**	☐	**Chalkdust/ Dust**	☐	**Food _____**
☐	**Strong Odors or Fumes**	☐	**Carpets in Room**	☐	**Molds**
☐	**Respiratory Infections**	☐	**Animals _____**	☐	**Latex**
☐	**Change in Temperature**	☐	**Pollens Spring/Summer/Fall**	☐	**Other:**

- **List all asthma medications taken each day (including at home).**

	Name	***Amount***	***When to Use***
1.	_____		
2.	_____		
3.	_____		

- **Comments and Special Instructions**

_____

_____

AUTHORIZATIONS:

PARENT/GUARDIAN:

☐ I want this plan to be implemented for my child at school

☐ I authorize my child to carry and self-administer asthma medications and I agree to release ASD and school personnel from all claims of liability if my child suffers any adverse reactions from self-administration and/or storage of asthma medication. **Yes** ☐ No ☐

☐ It is recommended that backup medication be stored with the school/school Nurse in case a student forgets or loses inhaler or inhaler is empty. The school district is not responsible or liable if backup medication is not provided to the school/school nurse and student is without working medication when medication is needed.

☐ **If school nurse is unavailable, I authorize delegation of emergency medications to staff trained by ASD nurse.**

Your signature gives permission for the nurse to contact and receive additional information from your healthcare provider regarding the asthma condition and the prescribed medication regimen.

Parent/Guardian Signature _____ Date _____

STUDENT AGREEMENT:

☐ I understand the signs and symptoms of asthma and when I need to use my asthma medication.

☐ I agree to carry my medications with me at all times.

☐ I will not share them or use my asthma medications for any other use than what it is meant for.

Student Signature_____ Date _____

SCHOOL AGREEMENT:

☐ Approved by School Nurse/School Principal. Back up medication is stored at school ☐ Yes ☐ No

☐

Trained Staff Name	***Title***	***Location/Rm #***	***Trained by (RN only)***

School Nurse/School Principal Signature _____ Date _____

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