Rockford Public Schools
Quality Community – Quality Schools
Together Building a Tradition of Excellence

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ASTHMA ACTION PLAN FOR SCHOOL USE

Student: _____

Date of Birth: _____

School: _____ Grade: _____

Parent/Guardian Name: _____

Phone:_____, _____

Trigger(s): ☐ Colds/flu ☐ Exercise ☐ Allergens ☐ Odors
☐ Weather ☐ Foods ☐ Other:_____

Actions for Asthma Episode:

1. **Stop all activity immediately**
2. **Allow student to remain in position of comfort- usually sitting up**
3. **Use quick-relief medication as indicated on care plan below**
4. **Contact parents, school nurse, and/or 911 as needed**

To be completed by a health care provider:

Green Zone: Doing well- breathing is good, no cough or wheezing, can work/play, sleeps well at night.

Control medication(s):

Medication	Dose	When and how often	Possess/self-administer
			☐ Yes ☐ No
			☐ Yes ☐ No

Physical activity- Use albuterol/levalbuterol ____ puffs ☐not required ☐ Before recess ☐ Before PE/Sports

Yellow Zone: Caution Take actions to help prevent an emergency- some problems breathing, cough, wheeze, or chest tight, problems working or playing, use when sick

Rescue Medicine(s): ☐ Albuterol/levalbuterol ____ puffs, every 4 hours as needed

Control Medicine(s): ☐ Continue green zone medicine(s)

☐ Add _____ ☐ Change to _____

You should feel better within 20-60 minutes of quick-relief treatment. If worsening, follow instructions in Red zone.

Red Zone: Emergency- Get Help Now – very short of breath, trouble walking, talking, quick-relief medication has not helped, cannot work/play

Take quick-relief medicine now ☐ Albuterol/levalbuterol ____ puffs, _____(frequency)

Other: _____

Call 911 immediately if the following signs are present:

- Trouble walking/talking due to shortness of breath
- Still in red zone 15 minutes after quick-relief medicine use
- Lips or fingernails are blue or grey
- Ribs showing or nose flaring

Healthcare Provider signature: _____ Date: _____

Printed name: _____ Phone Number: _____

As a parent/guardian of the above-named student, I give consent for an exchange of health information between the school nurse and healthcare provider. I give consent for exchange of information between the school nurse and appropriate school personnel. I authorize the administration of listed medication by trained school personnel. I acknowledge it is my responsibility to communicate any changes to my child's health condition, medications or needs to the school nurse. Orders are valid through the end of the current school year. *If your child in Medicaid eligible, school health services may be billed on behalf of the school. School district billing will not impact future benefits of your family's Medicaid plan. Orders are valid through the end of the current school year.

_____ (initial) As per the healthcare provider's authorization above, I request and give permission for my child to possess and self-administer the above emergency medication(s) during the school day and school sponsored events. My child has been instructed in the treatment plan and demonstrates an understanding of proper usage and self-administration of the above listed medication(s).

Parent Signature: _____ Date: _____