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**

Use a spacer when able- must be provided by parent/guardian

To be completed by a health care provider:

Green Zone: Doing well

Breathing well, no cough or wheezing, can work/play normally, sleeps well at night.

Medication	Dose	Frequency

Physical activity- Use _____ inhaler ____ puffs ☐ Before Exercise ☐ Only if having symptoms

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.

Medication	Dose	Frequency

You should feel better within 15-60 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

Medication	Dose	Frequency

Call 911 immediately if the following signs are present or improvement is not seen within 15 minutes of rescue medicine:

- 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

☐ **Yes** ☐ **No -** Student has permission to possess the designated medication(s) above at school and to self - administer such medication with or without supervision of school personnel. The student has been instructed in and demonstrates an understanding of proper usage.

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.

_____ (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: _____