Hillsdale Community Schools Asthma Action Plan

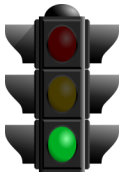
Name	Date of Birth	School/Teacher
Parent/Guardian	Parent/Guardian Phone	Parent/Guardian Email
Additional Emergency Contact	Contact Phone	Contact Email
Health Care Provider	Health Care Provider's Phone	Health Care Provider's Fax

Asthma Severity ❑ **Intermittent** *OR* **Persistent:** ❑ Mild ❑ Moderate ❑ Severe

Asthma Triggers (Things that make your asthma worse)
❑Colds ❑Smoke (tobacco, incense) ❑Pollen ❑Dust ❑Animals:_____❑Strong Odors ❑Mold/Moisture
❑Stress/Emotions ❑Exercise ❑Acid Reflux ❑Pests (rodents, cockroaches)
❑Season (circle): Fall, Winter, Spring, Summer ❑Other:_____.

Green Zone: Go! - Take these CONTROL (Prevention) Medicines EVERY Day

You have **ALL** of these:
- Breathing is easy
- No cough or wheeze
- Can work and play
- Can sleep all night



Peak Flow:
to_____.
(More than 80% of Personal Best)

❑No control medicines required.
❑Medication_____, _____puff(s) _____times a day
OR
❑Medication_____.
For asthma with exercise, ADD:
❑Albuterol or _____, _____puff(s) with spacer
_____minutes before ❑ALL activity ❑Only when child/nurse feels he/she needs it

Yellow Zone: Caution! - Continue CONTROL Medicines and ADD RESCUE Medicines

You have **ANY** of these:
- Cough or mild wheeze
- First sign of cold
- Tight chest
- Problems sleeping, working, or playing

Peak flow:_____to_____.
(60% - 80% of Personal Best)

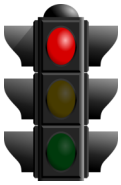
❑Albuterol or _____, _____puff(s) with spacer every _____hours as needed

❑Albuterol or _____, one nebulizer treatment(s) every _____ hours as needed

Call your Healthcare Provider if you need rescue medicine for more than 24 hours or two times a week, or if your rescue medicine doesn't work.

Red Zone: DANGER! - Continue CONTROL & RESCUE Medicines and GET HELP!

You have **ANY** of these:
- Can't talk, eat, or walk well
- Medicine is not helping
- Breathing hard and fast
- Blue lips and fingernails
- Tired or lethargic
- Ribs show



Peak flow: <_____.
(Less than 60% of Personal Best)

❑Albuterol or _____, ____puff(s) with spacer **every 15 minutes**, for **THREE** treatments

❑Albuterol or _____, one nebulizer treatment **every 15 minutes**, for **THREE** treatments

Call your doctor while administering the treatments.
IF YOU CANNOT CONTACT YOUR DOCTOR:
Call 911 or go directly to the Emergency Department NOW!

Required Signatures:
I give permission for school personnel to follow this plan, administer medication and care for my child and contact my provider if necessary. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I approve this Asthma Management Plan for my child.

Parent/Guardian_____ Date_____.

School Nurse/Designee_____ Date_____.

CC: ❑ Teacher ❑Other_____.

MEDICATION CONSENT/HEALTH CARE PROVIDER ORDER
(Check all that apply):

❑Student instructed in proper use of their asthma medication, and in my opinion, **CAN CARRY AND SELF-ADMINISTER INHALER AT SCHOOL.**

❑Student is to notify designated school health officials after using inhaler at school.

❑Student needs supervision or assistance to use inhaler.

❑Student should NOT carry inhaler while at school.

MD/NP/PA Signature_____Date_____.