WCSCC
WAYNE COUNTY SCHOOLS **CAREER CENTER**
Education at its Finest

Place Child's Picture Here

THIS FORM WILL EXPIRE AT THE END OF THE SCHOOL YEAR and START FROM THE TIME IT'S SIGNED BY THE PHYSICIAN AND PARENT/GUARDIAN

Asthma Action Plan

School Year: _____ Grade/Class: _____

Student's Name: _____ Date of birth: _____

Address: _____ City: _____ Zip: _____

Physician Name (Printed): _____ Physician Phone: _____

Triggers:	☐Mold ☐Pollen ☐Animals ☐Colds ☐Dust ☐Exercise ☐Smoke ☐Weather ☐Fragrance ☐Air Pollution ☐Food

Notify School Nurse and Parents/Guardian if 2 or more treatments are needed in the same day OR if a treatment is needed more than 2 days in a school week (excluding pretreatment before activity)

Emergency Contact Information

1. Parent/Guardian: _____Phone: _____
2. Emergency Contact: _____Phone: _____
3. Emergency Contact: _____Phone: _____

THE GREEN ZONE/SAFETY ZONE

Symptoms:	School Action:
○ Breathing is good ○ No Cough or Wheeze ○ Can do usual activities ○ Sleeps all night ○ Peak Flow meter if used=80-100%	○ None ○ Use long-term control medicines as prescribed

THE YELLOW ZONE/CAUTION ZONE

Symptoms:	School Action:
○ Some shortness of breath ○ Cough, wheeze, or chest tightness ○ Some difficulty doing usual activities ○ Sleep disturbed by symptoms ○ Symptoms of a cold or flu ○ Use of more quick-relief asthma medicine ○ Peak Flow meter if used=50-60%	○ Take quick relief medication ○ If symptoms improve after 15 minutes-return to normal activity ○ If symptoms do not improve after 15 minutes-Give quick relief medication again and call parent/guardian ○ If symptoms do not improve after medication is repeated-

Asthma Action Plan Continued: Students Name: _____

THE RED ZONE/DANGER ZONE

Symptoms:	School Action:
○ Severe breathing problems (coughing constantly, extreme shortness of breath, skin retracts between the ribs or at the neck) ○ Cannot do usual activities ○ Symptoms are same or worse after 24 hours in the Yellow Zone ○ Difficulty walking or talking ○ Quick-relief asthma medications is not helping ○ Peak flow less than 50% of personal best	○ Use Quick-relief asthma medication ○ Contact Parent/Guardian ○ Contact Physician Immediately ○ Transport to hospital by EMS if needed

PHYSICIAN AUTHORIZATION FOR POSESSION AND USE OF ASTHMA INHALER

Medication Name: _____

Dosage: _____

Frequency: _____

Adverse reactions that should be reported to provider: _____

Procedure other than what is described in the action plan that the physician wishes the school to follow in an event the medication does not produce the expected relief from student's asthma attack:

_____

HEALTHCARE PROVIDER: Please initial here _____IF STUDENT has been instructed on how to use the inhaler and spacer and is able to self-administer; thus, **enabling the student to carry the inhaler.**

PARENT/GUARDIAN AND STUDENT: Please initial here _____/_____ to indicate you have been instructed and can self-administer the inhaler and will alert an adult or school nurse in the event the inhaler is not giving relief. All medication must be labeled with the information/label from the pharmacy. You can provide the school nurse with the original box, and she can label the inhaler if needed.

AGREEMENT: PARENTS ARE RESPONSIBLE FOR PROVIDING ALL NECESSARY MEDICATION TO THE CLINIC IN A TIMELY MANNER. IF STUDENT SELF CARRIES THE SCHOOL NURSE STILL NEEDS TO MAKE SURE THE INHALER IS LABELED CORRECTLY

- I am requesting permission for my child named above to receive medication in accordance with this action plan. I will assume responsibility for safe delivery of the medication/drug to school. The medication must be brought to school in the container in which it was dispensed by the prescriber or licensed pharmacist.
- I will notify the school immediately if there is any change in the use of the medication or prescribed treatment. A revised action plan will need to be on file signed by the prescriber.
- I release and agree to hold the Board of Education, it's officials, and it's employees harmless from all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

Signatures: Represent agreement with the above Information/Action Plan

PARENT/LEGAL GUARDIAN: _____ Date: _____

HEALTHCARE PROVIDER SIGNATURE: _____Date: _____

SCHOOL NURSE: _____ _Date: _____