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Dr. William C. Hardin, Superintendent

Student Asthma Action Plan for _____

Physician Name: _____ Physician Phone: _____

Emergency Plan

Emergency action is necessary when the student has symptoms such as:

- Tightness in chest Increase in Breathing Rate Peak flow reading of _____
 Excessive/increased Cough Wheezing
 Chest/Neck pull in with breathing

Step 1: If student has any of the above listed symptoms, *give medications as listed below* and check peak flow. Follow instructions below.

GREEN ZONE Good Response	YELLOW ZONE Fair Response	RED ZONE Poor Response
*Breathing rate normal *Skin color pink *Alert and active *No chest tightness *No cough	*Breathing rate normal or increasing *Mild difficulty breathing *Skin color pink *Mild cough *Mild chest tightness *Peak flow _____ to _____	*Breathing rate fast *Severe Breathlessness *Skin pulling between ribs with each breath *Nasal flaring *Continual cough *Peak flow _ _____ to _____



Return to Normal Routine	Call Parent and continue to observe.	Get Emergency Treatment!
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Emergency Asthma Medications:

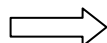
Name	Amount	When to Use
1. _____		
2. _____		

Daily Asthma Management Plan

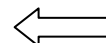
Identify the things which start an asthma episode (Check each that applies to student.)

- | | | |
|---|--|----------------------------------|
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Strong odors or fumes | <input type="checkbox"/> Animals |
| <input type="checkbox"/> Respiratory infections | <input type="checkbox"/> Chalk dust/ dust | <input type="checkbox"/> Pollens |
| <input type="checkbox"/> Change in temperature | <input type="checkbox"/> Carpets in the room | <input type="checkbox"/> Molds |
| <input type="checkbox"/> Food _____ | <input type="checkbox"/> Other _____ | |

Comments: _____



****See reverse for more instructions****



Control of School Environment

(List any pre-medications, and/or dietary restrictions that the student needs to prevent an asthma episode.)

Peak Flow Monitoring

Personal best peak flow number: _____ Monitoring times: _____

Daily Medication Plan

	Name	Amount	When to use
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Comments/Special Instructions

**Parent/Guardian Signature* _____ *Date* _____

FOR INHALED MEDICATIONS-MUST BE COMPLETED BY PHYSICIAN, STUDENT, AND PARENT IF STUDENT IS ALLOWED TO CARRY INHALER WITH THEM.

___ I have instructed this student in the proper way to use his/her inhaler. It is my professional opinion that he/she should be allowed to carry and use the inhaler by him/herself. It is preferable that a second prescription labeled inhaler be kept in the clinic in case the first is lost or left at home.

Physician Signature or Stamp Date

___ It is my professional opinion that this student should keep an inhaler in the school clinic for use as prescribed.

Physician Signature or Stamp Date

___ I have been instructed in the proper use of my prescription labeled medication and fully understand how to administer this medication. I will not allow another student to use my medication under any circumstances. I also understand that should another student use my prescription, the privilege of carrying my medication may be revoked. I also accept the responsibility for checking in with the school nurse to keep her informed of use of my medication in case I start having problems.

Student Signature Date

___ I hereby request that the above named student, over whom I have legal control, be allowed to carry and use the prescription medication described above, at school. I accept legal responsibility should the above medication be lost, given or taken by a person other than the above named student. I understand that if this should happen, the privilege of carrying the medication may be revoked. I release the Camden County School district and its employees of any legal responsibility when the above named student administers his/her own medication.

Parent/Guardian Signature Date