Lomira School District

Asthma Action Plan

Students Name:	Birthdate:
School Year:	Grade:
Parent/Guardian:	Daytime Phone Number:
Other Contact:	Phone:
Bus Student: Yes No	Physician:

Triggers: ( ) Weather ( ) Illness ( ) Exercise ( ) Smoke ( ) Dog/Cat ( ) Dust ( ) Mold ( )Pollen

Other: _____

GREEN ZONE: PRETREATMENT STEPS FOR EXERCISE (Health provider please complete section)

( ) Give 2 puffs of rescue med (name) _____ 15 minutes before activity (Circle indication: Phys Ed Class, exercise/sports, recess) Explanation: _____

( ) Repeat in 4 hours if needed for additional or ongoing physical activity

YELLOW ZONE: SICK-UNCONTROLLED ASTHMA (Health provider please complete section)

IF YOU SEE THIS:	DO THIS:
• Difficulty breathing • Wheezing • Frequent Cough • Complains of chest tightness • Unable to tolerate regular activities, but still talking in complete sentences • Other:	• Stop physical activity • Give rescue med (name): _____ ( ) 1 puff ( ) 2 puffs ( ) Via Spacer ( ) Other:_____ • If no improvement in 10-15 minutes, repeat use of rescue med: ( ) 1 puff ( ) 2 puffs ( ) Via Spacer ( ) Other: _____ • If student's symptoms do not improve **CALL 911** • Stay with student and maintain sitting position • Call parents/guardians and school nurse • Student may resume normal activities once feeling better

RED ZONE: EMERGENCY SITUATION (Health provider please complete section)

IF YOU SEE THIS:	DO THIS IMMEDIATELY
• Coughs constantly • Struggles or gasps for breath • Trouble talking (can speak only 3-5 words) • Skin of chest and/or neck pull in with breathing • Lips or fingernails are gray or blue • Decreased level of consciousness	• Give rescue med (name): _____ ( ) 1 puff ( ) 2 puffs ( ) Via Spacer ( ) Other:_____ • If no improvement in 10-15 minutes, repeat use of rescue med: ( ) 1 puff ( ) 2 puffs ( ) Via Spacer ( ) Other: _____ • **CALL 911** Inform attendant the reason for the call in asthma • Call parents/guardians and school nurse • Stay with student and remain calm

Students in grades 6-12 are permitted by law to possess and use inhalers independently with physician's signature.

Level of independence recommended for this student:

- _____Totally independent (Has been trained by physician on use and is prepared to self-administer)
- _____Inhaler is kept by designated school personnel and used under supervision.
- _____Other _____

Medication Consent: I hereby give permission to designated trained school personnel to give medication to my child during the school day, including when away from school property on official school business, according to the written instructions of the doctor as shown on this form. I also hereby agree to give my permission to the school nurse and/or school personnel to contact the child's physician if needed.

I hereby give permission to designated school personnel to notify other appropriate school personnel and classroom teachers of medication administration and possible adverse effects of the medication.

I further agree to hold the Lomira School District, and its employee(s) who is (are) administering the medication harmless in any or all claims arising from the administration of this medication at school. I agree to notify the school at the termination of this request or when any change in the above orders is necessary.

( ) Yes ( ) No Authorization is hereby granted to release this information to appropriate school personnel and teachers.

Physician Signature:	Date:
Parent/Guardian Signature:	Date: