

# ASTHMA ACTION FORM

Required any student having Asthma

Name \_\_\_\_\_ Grade \_\_\_\_\_ ALLERGIES \_\_\_\_\_ DIAGNOSIS \_\_\_\_\_

## ASTHMA/INHALER SECTION

Medication/Inhaler \_\_\_\_\_ Dosage \_\_\_\_\_ q \_\_\_\_\_ Hours

Neb Treatment- Name/Medication \_\_\_\_\_ Dosage \_\_\_\_\_ q \_\_\_\_\_ Hours

Benadryl  25mg  50mg PRN as per label instructions for Hives, Allergy, Reactions, will call parent if given.

If needed, how soon can administration of medication be repeated? \_\_\_\_\_ Cannot be repeated more than \_\_\_\_\_

Side effects of medications listed \_\_\_\_\_

### PHYSICAL EDUCATION CLASS: INHALER TO BE GIVEN

30 min prior to gym class everyday  30 min prior to strenuous exercise  30 min prior to running only e.g. 1 mile run  plus PRN  PRN only

### SELF CARRY INHALERS IN SCHOOL AND FIELD TRIPS:

Self admin. with inhaler in Nurse's office  Self admin. and carry fulltime on self

**Note: Elementary School Inhalers given to teacher/chaperone \*Middle School: Inhaler will be given to student to self-carry during all FIELD TRIPS**

## ASTHMA ACTION PLAN

**Green Zone** – Breathing is easy, Can play, Work without symptoms\* **PEAK Flow Range 80%-100%** of Personal Best

<input type="radio"/>	Medications _____	Dose _____	Freq _____	Hours _____
<input type="radio"/>	_____	Dose _____	Freq _____	Hours _____
<input checked="" type="radio"/>				

**Yellow Zone-** Breathing easy, Coughing or Wheeze, Chest tight, SOB, **PEAK Flow Range 50%-80%** of Personal Best

<input type="radio"/>	Medication _____	Dose _____	Freq _____	Hours _____
<input checked="" type="radio"/>	Nebulizer _____	Dose _____	Freq _____	Hours _____
<input type="radio"/>				

**Red Zone** Medicine NOT working, Nose open wide to breath, Breathing is hard and fast, Trouble walking and talking, Ribs show

**If Symptoms do not get better Call 911** **PEAK Flow Range below 50%**

<input checked="" type="radio"/>	Medication _____	Dose _____	Freq _____	Hours _____
<input type="radio"/>	Nebulizer _____	Dose _____	Freq _____	Hours _____
<input type="radio"/>	May repeat dose? _____	In _____	Minutes _____	<b>IF STUDENT STAYS IN RED ZONE, CALL 911</b>

School Emergency Plan: If student has a) no improvement 15-20 minutes AFTER initial treatment with quick-relief medications, b) Peak flow of <50% of usual best, c) trouble walking or talking, or d) chest/neck muscle retractions with breaths, hunched or blue color

**CALL 911 IMMEDIATELY**

I hereby certify that (name) \_\_\_\_\_ has been instructed in the use and self-administration of the medications described herein. The student understands the need for the medication and the necessity to report to school personnel any side effects. He/She is capable of using this medication independently? The student understands the importance of not sharing medication with other students  Yes  No

### Parent Statement and Authorization

I hereby confirm my primary responsibility to administer medication to my child. However, in the event that I am unable to do so, I hereby authorize Pleasantdale School District 107 and its employees and agents, in my behalf, to administer or to attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the employees and agents of the District), lawfully prescribed medication in the manner described above. **I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse and specifically consent to such practices.** I further acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against the District, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the District, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts of said medication.

Your child's medical concerns will be shared with only appropriate personnel: Principal, Teachers, Front office Secretaries, Nurse, Librarian, Lunch & Playground monitors, Bus driver **by signing this Asthma Inhaler and Action Plan you agree that the information is share with and included on the confidential medical concerns list.**

Parent Signature +Date

Physician Signature + Date (Required)