New Albany-Floyd County Consolidated School Corporation
Health Services
2023-2024 School Year

Asthma Action Plan

Attach child's photo

Child's name: _____ School: _____
Teacher:_____Grade:_____ Date of birth: ____/____/_____ Age _____
Parent/Guardian: _____ Phone: _____
Other Emergency Contact: _____ Phone: _____
Treating Physician: _____ Phone: _____ Fax: _____
Significant Medical History: _____

TO BE COMPLETED BY ASTHMA CARE PROVIDER

RESCUE (quick-relief) MEDICATION: _____

MONITORING	TREATMENT
RED **RED ZONE: DANGER SIGNS** • Very short of breath, or • Rescue medicines have not helped, or • Cannot do usual activities, or • Symptoms are same or get worse after 24 hours in Yellow Zone **RED ZONE: EMERGENCY SIGNS** • Lips and fingernails are blue or gray • Trouble walking and talking due to shortness of breath • Loss of consciousness	• Give rescue medication: ❒ 2 ❒ 4 ❒ 6 puffs (1 min between puffs) or 1 nebulizer treatment • **Call parent and/or Asthma Care Provider** • **Call 911 NOW if:** 1. Unable to reach medical care provider after arriving in the red zone 2. Child is struggling to breathe and there is no improvement after taking albuterol 3. May repeat rescue medication every 10 minutes if symptoms do not improve, until medical assistance has arrived or you are at the emergency department
YELLOW **YELLOW ZONE: CAUTION** • Cough, wheeze, chest tightness, or shortness of breath, or • Waking at night due to asthma, or • Can do some, but not all, usual activities	• Continue daily controller medications • Give rescue medication: ❒ 2 ❒ 4 ❒ 6 puffs (1 min between puffs) OR 1 nebulizer treatment every 4 hours as needed • Wait 10 minutes and recheck symptoms • **If not better, go to RED ZONE** • **If symptoms improve, may return to class or normal activity, or** _____ _____ • **Parent/School Nurse:** If needed, coordinate rescue medications to be given every 4 hours for ❒ 2 ❒ 3 days, if symptoms remain improved • If symptoms are not gone after ❒ 2 ❒ 3 days, move to the **RED ZONE**
GREEN **GREEN ZONE: WELL** • No cough, wheeze, chest tightness, or shortness of breath during the day or night • Can do usual activities	**MEDICATION** / **HOW MUCH** / **WHEN** (blank) / (blank) / **Before Exercise** ❒ Recess ❒ PE/Sports *(not to exceed every 4 hours)* **DAILY CONTROLLER MEDICATION** / **HOW MUCH** / **WHEN** (blank) / (blank) / (blank) (blank) / (blank) / (blank) (blank) / (blank) / (blank)

❒ Administer medications as instructed above
❒ Student has been instructed in the proper use of all his/her asthma medications, and in my opinion, the student can carry and use his/her inhaler at school
❒ Student needs supervision or assistance to use his/her inhaler medication
❒ Student should **NOT** carry his/her inhaler while at school ❒ Have student use spacer with inhaler medication

_____ _____ _____
ASTHMA CARE PROVIDER SIGNATURE **PLEASE PRINT PROVIDER NAME** **DATE**

I give permission for the school nurse and any pertinent staff caring for my child to follow this plan, administer medication and care for my child, contact my asthma care provider if necessary and for this form to be faxed/emailed to my child's school or be shared with school staff per FERPA guidelines. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices.

_____ _____
PARENT SIGNATURE **DATE**

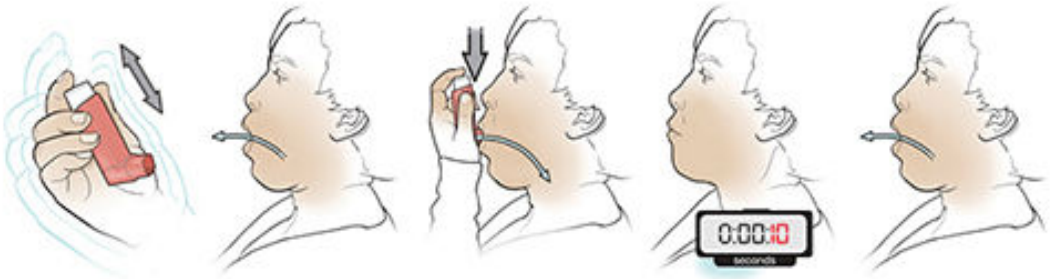
Asthma Action Plan page 2

Child's name: _____

<u>*Parent/Guardian, please note:</u>

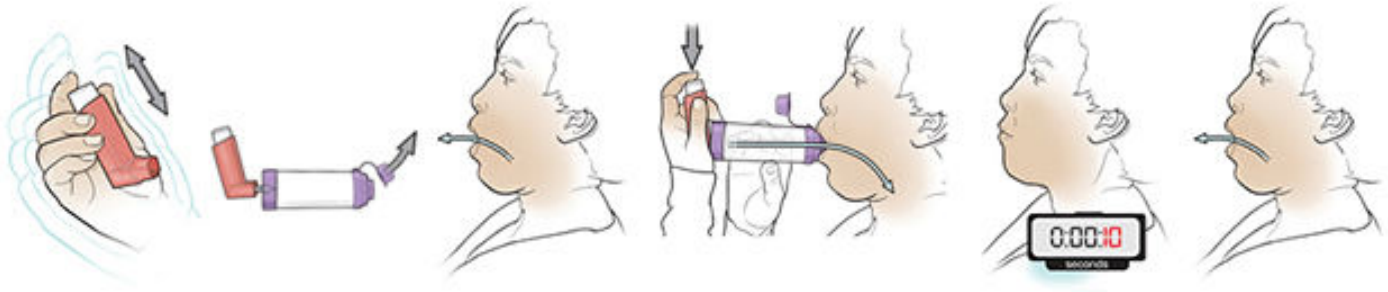
By signing page 1, I give permission to the School Nurse and other trained personnel members to perform the tasks as outlined in the Asthma Action Plan. I understand that a School Nurse is not always present at my child's school and I give consent for other trained school personnel to provide care to my child as needed according to this plan. I give permission for the School Nurse and prescribing Health Care Provider to exchange information regarding any necessary medication order clarifications, response to medication, and adverse effects. I also consent to the release of information contained in this Asthma Action Plan to staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety. Unless other arrangements are made, I give the school permission to send home medication that has been in its possession with my child at the end of the school year.

Proper inhaler use without spacer:



Remove cap and shake inhaler. | Breathe out all the way. | Breathe in and press down on the inhaler. | Hold your breath for a count of 10. | Slowly breathe out.

Proper inhaler use with spacer:



Remove cap and shake inhaler. | Insert inhaler into spacer. | Breathe out all the way. | Press down on the inhaler. Slowly breathe in. | Hold your breath for a count of 10. | Slowly breathe out.

For School Personnel:

Please note:

- **If 911 is called and a student is transported to the hospital, NAFCS staff must accompany the student in the ambulance unless parent and/or emergency contact accompanies them.**
- **Document event and any medications given.**
- **Ensure assistive personnel notifies ASC if a 911 call is made.**
- **If prescribed medical treatment is not available to school personnel, call EMS for any signs/symptoms noted on page 1 that require calling 911. Contact the School Nurse.**
- **Please ensure rescue medication is taken on all field trips.**
- **Be sure to share this information with any substitute teacher.**

Personnel who are trained including the date of training:	Location of supplies:
1. _____ Date _____ 2. _____ Date _____ 3. _____ Date _____ 4. _____ Date _____ 5. _____ Date _____ 6. _____ Date _____ 7. _____ Date _____ 8. _____ Date _____ 9. _____ Date _____ 10. _____ Date _____	☐ Health office ☐ With student_____ ☐ Classroom ☐ Specials classrooms ☐ Bus ☐ Other _____

This plan has been reviewed and approved by:	Copies of HCAP given to/Date given:
_____ School Nurse's Signature Date _____ Building Principal's Signature Date	Health Office _____ Teacher (Elem)_____ Principal_____ TOR (Sped) _____ Cafeteria_____ IEP(Sped) _____ ESC (Sped)_____ Bus/Aide_____ Transportation (if med in backpack for use on bus)_____ All trained staff_____