Broward County Public Schools

SCHOOL ASTHMA ACTION PLAN

9/28/10

Student Name___________________________________ Date of Birth _____________School______________________________

Student ID Number___________________________ Grade ____Medication Allergies______________________________________

Activities student participates in at school: ____

Asthma symptoms are triggered by**:**

☐Exercise ☐Pollen ☐Smoke ☐Dust ☐Air Pollution ☐Animals ☐Cold Air ☐Molds ☐Foods (list)

Please list any other triggers: ____

Usual Asthma Symptoms: ☐Cough ☐Shortness of Breath ☐Chest Tightness ☐Wheeze ☐Other___________

If a student has *any* of the following symptoms: chest tightness, difficulty breathing, wheezing, excessive coughing, shortness of breath **1. Stop activity & help student to a sitting position** **2. Stay calm, reassure student** **3. Assist student with the use of their inhaler** **4. Escort student to the health room or call for health room staff for immediate assistance. Never send the student to the health room alone!** **INHALER IS KEPT: ____________________________**	**Call 911 for *any* of these!** • **If breathing does not improve after medication is given** • **Student is having trouble walking or talking** • **Student is struggling to breathe** • **Student's chest and/or neck is pulling in while breathing** • **Student's lips are blue, and/or** • **Student must hunch over to breathe**

***HEALTH CARE PROVIDER, Please* complete *all* items in box:** ICD 9 Code: ☐493.9 or _________

Asthma Severity: ☐Intermittent ☐Mild persistent ☐Moderate persistent ☐Severe persistent

Controller Medication given at home:

____

Name of Medication how much/mgs how often

____

Name of Medication how much/mgs how often

Quick Relief Medication:

_________puffs every ___ min. and as needed up to ___ puffs per hour. May repeat every___hrs

__________ 10-15 min before exercise ☐Routinely ☐As Needed Activity limitations: ______________

OR, Albuterol or (____________________) solution as needed, ______ mg by nebulizer every ____ to ____hours

Name of Medication how much

GREEN ZONE: DOING WELL	YELLOW ZONE: NOT GOOD	RED ZONE: MEDICAL ALERT
*Peak Flow___________________ 80 to 100% of personal best	*Peak Flow___________________ 50 to 80% of personal best	*Peak Flow___________________ Less than 50% of personal best
Asthma Symptoms ■ No Cough, wheeze or shortness of breath ■ Able to do all normal activities including exercise and play ■ No symptoms at night ■ No need for quick relief medications for symptoms	**Asthma Symptoms** ■ Coughing, wheezing, shortness of breath, or chest tightness ■ Using quick relief medication more than usual ■ Can do some but not all of usual activities ■ Asthma symptoms at night	**Asthma Symptoms** ■ Medication unavailable or not working ■ Getting worse not better ■ Breathing hard and fast ■ Chest/neck pulling in ■ Difficulty walking or talking ■ Lips or fingernails blue ■ Hunched over to breathe
Use daily controller medications. Use quick relief inhaler before exercise as ordered. *Peak flow readings may be obtained by trained school personnel.	**Take Quick Relief Medication Now!** Add or change these medications: ______________________________ Name of medication How much How often Parent/guardian-call medical provider if using quick relief medication more than twice a week or no symptom improvement.	**Take Quick Relief Medication Now!** ***Call 911 & continue to give Quick Relief Medication every 20 minutes until EMS arrives!*** Contact Parent & Provider-See Below

Student can self carry medication? ☐Yes ☐No **Student can self-administer medication?** ☐Yes ☐No

Health Care Provider Signature ____ **Date** ________________

Health Care Provider Name Printed_____________________________________

Provider phone________________________**Provider fax**______________________**Provider email**________________

Parent/Guardian Signature ______________________________**Date** ________ **Parent Home telephone** __________

Parent work telephone ______________ **Parent cell number** _______________

School staff trained to administer and/or assist with medication administration

__________________________/ ________________________/____________________________/________________________

School Nurse /On-Call Nurse Signature ____________________________ **Date** ___________ **Phone**__________________