Asthma Management Plan

Name: _____ **DOB:**_____

School:_____ **Grade/Teacher:**_____

Doctor: _____ **Practice:**_____

Phone for Doctor or Practice:_____

Asthma Triggers

Try to stay away from or control these things:

- □ Exercise
- □ Mold
- □ Chalk dust/dust
- □ Pollen
- □ Animals
- □ Cockroaches
- □ Smoke, strong odors or spray
- □ Colds/Respiratory infections
- □ Carpet
- □ Change in temperature
- □ Dust mites
- □ Food _____

1. Green – Go

- Breathing is good, no cough or wheeze
- Can work and play

Or Peak Flow _____ to _____(80-100%)

Use these controller medicines *every day* to keep you in the green zone:

Medicine: How much to take: When to take it: □ Home □ School

_____

_____

5-15 minutes before very active exercise, use □ Albuterol_____(puffs).

2. Yellow – Caution

Coughing

Wheezing

Tight Chest

Wakes up at night

Or Peak Flow _____to _____ (50-80%)

***Keep* using controller green zone medicines everyday.**

***Add* these medicines to keep an asthma attack from getting bad:**

Medicine	How much to take	When to take it
Albuterol or _____	□ 2 puffs by inhaler □ 4 puffs by inhaler □ with spacer, if available □ by nebulizer	□ May repeat every 20 min up to 3 doses in first hour, if needed

If symptoms ***DO NOT*** improve after first hour of treatment, then go to ***red zone.***

If symptoms ***DO*** improve after first hour of treatment, then continue:

Albuterol or _____ □ 2 puffs by inhaler □ 4 puffs by inhaler □ with spacer, if available □ by nebulizer — □ Every 4 - 8 hours for _____ days

_____, _____times a day for _____days □ Home □ School

(oral corticosteroid) *(how much)*

Call your doctor if still having some symptoms for more than 24 hours!

3. Red – Stop – Danger

- Medicine is not helping.
- Breathing is hard and fast.
- Nose opens wide.
- Can't walk.
- Ribs show.
- Can't talk well.

Or Peak Flow _____ (Less than 50%)

Call* your doctor and/or parent/guardian *NOW!

***Take these medicines* until you talk with a doctor or parent/guardian:**

Medicine:	How much to take:	When to take it:
Albuterol or _____	□ 2 puffs by inhaler □ 4 puffs by inhaler □ with spacer, if available □ by nebulizer	□ May repeat every 20 minutes until you get help

_____, _____times a day for _____days □ School □ Home

(oral corticosteroid) *(how much)*

Call 911 for severe symptoms, if symptoms don't improve, or you can't reach your doctor and/or parent/guardian.

☐ **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 this medication and administer to himself/herself.**

Physician's Signature _____ **Date:**_____

Physicians name & address STAMP

Asthma Management Plan

School Action Plan

Name of Student: _____ DOB: _____

School: _____ Grade/Teacher: _____

All medication for use at school will be furnished by parent or guardian in a container properly labeled by a pharmacist with identifying information (e.g., name of child, medication dispensed, dosage prescribed, and the time it is to be given or taken).

Parent Permission

☐ **I give permission for my child to carry and self-administer his/her inhaler.**
*Parent/guardian must provide an extra inhaler to be kept at school in case of emergency.

☐ **I DO NOT give permission for my child to carry and self-administer his/her inhaler.**

I hereby give my permission for my child to receive medication during school hours. This medication has been prescribed by a licensed physician. I hereby release Neuse Charter School Board of Directors and their agents and employees from all liability that may result from my child taking the prescribed medication. This consent is good for one year, unless revoked.

I give permission to designated staff members of Neuse Charter School to perform and carry out the tasks as outlined by this Asthma Action Plan. I also consent to the release of the information contained in this Asthma Action Plan to all staff members and other adults who have custodial care of my child and who need to know this information in order to maintain my child's health and safety.

Acknowledged and received by:

Parent/Guardian _____ Date _____

Parent Email address _____ Parent Phone Numbers _____

EMERGENCY CONTACTS: Name/Relation

1._____a) home_____ b) work _____ c) cell_____

2._____a) home_____ b) work _____ c) cell_____

3._____a) home_____ b) work _____ c) cell_____

Principal's Signature _____ Date _____

School First Responder's Signature _____ Date _____