

# STUDENT ASTHMA ACTION CARD

Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Teacher \_\_\_\_\_  
 School Nurse: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Health Care Provider Treating Student for Asthma: \_\_\_\_\_ Ph: \_\_\_\_\_  
 Preferred Hospital \_\_\_\_\_  
 My Personal Best Peak Flow Reading: \_\_\_\_\_ (If Applicable)

*ID Photo*

## Green Zone: All Clear

- Breathing is easy. No asthma symptoms with activity or rest
- Peak Flow Range: \_\_\_\_\_ to \_\_\_\_\_ (80 to 100% of personal best) *If applicable.*
- Pre-medicate if needed 10 to 20 minutes before sports, exercise or other strenuous activity.**
- Pre-exercise medications listed in #1 below.**

## Yellow Zone: Caution

- Cough or wheeze. Chest is tight. Short of breath.
- Peak Flow Range: \_\_\_\_\_ to \_\_\_\_\_ (50 to 80% of personal best) *If applicable.*
- Medicate with quick reliever. Give medications as listed below.
- May re-check peak flow in 15 to 20 minutes.
- Student should respond to treatment in 15-20 minutes and return to green zone, if not contact parent.

## Red Zone: Emergency Plan

- Call EMS if student has any of the following:
  - ✓ Coughs constantly
  - ✓ No improvement 15-20 minutes after initial treatment with medication
  - ✓ Hard time breathing with some or all of these symptoms of respiratory distress:
    - Chest and neck pulled in with breathing
    - Stooped body posture
    - Struggling or gasping
  - ✓ Trouble with walking or talking due to shortness of breath
  - ✓ Lips or fingernails are grey or blue
  - ✓ Peak flow below: \_\_\_\_\_. (50% of personal best) *If applicable.*
- Medicate with quick reliever. Give medications as listed below.
- Re-check peak flow in 15 to 20 minutes.
- Student should respond to treatment in 15-20 minutes.
- Contact parent/guardian.

### Emergency Asthma Medications-*to be completed by Health Care Provider*

	Name	Amount
1.	_____	_____
2.	_____	_____

### Health Care Provider AUTHORIZATION:

- This child has received instruction in the proper use of his/her asthma medications.
- It is my professional opinion that this student *should/should not* (Circle one) be allowed to carry, store and use his/her asthma medications by him/herself.

**Health Care Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*Side 2 to be filled out by Parent/Guardian, Student, and School*

**Side 2: To Be Completed by Parent/Guardian and Student**STUDENT ASTHMA ACTION CARD *(continued)* Student Name: \_\_\_\_\_ D.O. B. \_\_\_\_\_**DAILY ASTHMA MANAGEMENT PLAN**

• **Identify the things which start an asthma episode (If known, check each that applies to the student. These should be excluded in the student's environment as much as possible.)**

- |   |   |                                      |
|---|---|--------------------------------------|
| <input type="checkbox"/> Exercise               | <input type="checkbox"/> Chalk dust/dust              | <input type="checkbox"/> Food _____  |
| <input type="checkbox"/> Strong odors or fumes  | <input type="checkbox"/> Carpets in the room          | <input type="checkbox"/> Molds       |
| <input type="checkbox"/> Respiratory infections | <input type="checkbox"/> Animals _____                | <input type="checkbox"/> Latex       |
| <input type="checkbox"/> Change in temperature  | <input type="checkbox"/> Pollens (Spring/Summer/Fall) | <input type="checkbox"/> Other _____ |

• **List all asthma medications taken each day.**

Name	Amount	When to Use
1. _____		
2. _____		
3. _____		

**COMMENTS / SPECIAL INSTRUCTIONS**


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**AUTHORIZATIONS****Parent/Guardian:**

- I want this plan to be implemented for my child in school.
- I authorize my child to carry and self-administer asthma medications and I agree to release the school district and school personnel from all claims of liability if my child suffers any adverse reactions from self-administration and/or storage of asthma medications.  **Yes**  **No**
- It is recommended that backup medication be stored with the school/ school nurse in case a student forgets or loses inhaler or inhaler is empty. The school district is not responsible or liable if backup medication is not provided to the school/ school nurse and student is without working medication when medication is needed.

**Your signature gives permission for the nurse to contact and receive additional information from your health care provider regarding the asthma condition and the prescribed medication.**

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Student Agreement:**

- I understand the signs and symptoms of asthma and when I need to use my asthma medication.
- I agree to carry my medication with me at all times.
- I will not share my or use my asthma medications for any other use than what it is prescribed for.

**Student Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Approved by School Nurse/School Principal  Back-up medication is stored at school  Yes  No

**School Nurse/Principal Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_