Selinsgrove Area School District
Asthma Action Plan

Name_____**Grade**_____**Teacher**_____**School Year**_____

Asthma Severity Classification: Mild_____ **Moderate**_____ **Severe** _____

Asthma Triggers (list):_____

Green Zone: Doing well • Breathing is good • No cough or wheeze • Can work and play • Sleeping at night	**GREEN ZONE** **Daily Controller Medications**_____ **Quick Relief Medication: Name**_____ **Puffs**_____ **How often**_____ **Exercise: Albuterol 2 puffs 15-30 min prior to exercise Yes No** **Notes:**
Yellow Zone: Having Problems • Some problems breathing • Cough, wheeze, tight chest • Wake up at night • First sign of a cold	**YELLOW ZONE** **Continue Controller Medications** **Take Albuterol** _____ **puffs every**_____ **Take Albuterol prior to controller medications** **Call your physician if no improvement. PCP or ER for any increased work of breathing or shortness of breath**
Red Zone: GET HELP! • Medicine is not helping • Nostrils flare when breathing • Hard to walk or to talk in sentences • Ribs or neck muscles show when breathing	**RED ZONE** **You must call and be seen by a medical health care provider** **Take Albuterol via nebulizer EVERY** _____ **minutes x**_____ **OR** **Take Albuterol** _____ **puffs EVERY**_____ **minutes x** _____**, then EVERY**_____ **hours** **Go to the hospital or call 911 if not improving or worsening**

Provider name and signature:_____ **Date**_____

_____**I agree that student is able to self-carry and administer his/her inhaler while at school/school sponsored events**

(Provider initials)

SELF-ADMINISTER/CARRY ON PERSON: ASTHMA MEDICATIONS (optional)

_____**YES, I want my child to be able to carry his/her Asthma inhaler on the bus, field trips or during school.**

To Carry or Self-medicate, the student must be able to: (parent- please initial)

_____1. Respond to and visually recognize his/her name.
_____2. Identify his/her medication.
_____3. Demonstrate the proper technique for self-administering his/her medication.
_____4. Inform the school nurse that the inhaler was used.
_____5. Demonstrate a cooperative attitude in all aspects of self-administration of medication.

As the parent/guardian of the above named student, I relieve the school district and its employees of any responsibility for the benefits or consequences of the above listed medication(s) when it is physician-prescribed and parent/guardian authorized. I further acknowledge that the school bears no responsibility for ensuring that the medication is taken. I am aware that any improper use/sharing of the above named medication will result in the immediate confiscation of the inhaler and loss of privilege to self-administer if the medication policy is violated. Parent/Guardian will be notified if this occurs.

_____NO, I do not want my child to carry or self –administer his/her inhaler at school or on field trips

I hereby give my permission for the medication(s) listed above to be given to my child by the School Nurse or the designee of the nurse. I relieve the Selinsgrove Area School Board and its employees of liability in the administration of this medication. I agree to allow the school nurse or designee to contact the prescribing physician concerning medication(s) if necessary.

PARENT/GUARDIAN SIGNATURE_____**DATE** _____

STUDENT COMMITMENT to Self-Administer

I agree to be solely responsibility for my asthma inhaler and to follow the directions for its use as ordered by my physician, as well as the district's medication policy. I agree to inform the nurse if I need to use my inhaler during the school day. I am aware that any abuse of this privilege will result in the confiscation of my inhaler and the loss of the privilege.

Student signature_____ **Date**_____