SAINT BRIGID OF KILDARE SCHOOL

St. Brigid of Kildare School

5141.0
Revised 8/16/21

Asthma Action Plan and Orders

Student's name: _____ Birthdate: _____ Phone: _____

Student's address: _____ Grade: _____
street city state zip

I. Healthcare Provider's Section

Severity classification ☐ Intermittent ☐ Mild persistent ☐ Moderate persistent ☐ Severe persistent
Asthma triggers ☐ none ☐ animals ☐ cold air ☐ exercise ☐ pollen ☐ respiratory illness
☐ smoke, chemicals, strong odors ☐ other (food, emotions, insects, etc.) _____
Peak flow meter personal best _____

Quick relief medication orders: (check the appropriate quick relief med(s)) ☐ Uses inhaler with spacer
☐ Albuterol (strength _____): ____ puffs (Proair®, Ventolin HFA®, Proventil®) as needed every ____ hours for cough/wheeze
☐ Levalbuterol (strength _____): ____ puffs (Xopenex®) as needed every ____ hours for cough/wheeze
☐ Other _____ Epi auto-injector ☐ 0.3 mg ☐ Jr.0.15 mg

SIDE EFFECTS of medication(s): _____

Green Zone: Doing Well
Symptoms: Breathing is good – No cough or wheeze
Peak flow meter _____ (more than 80% of personal best)
Physical activity: ☐ Use albuterol/levalbuterol ____ puffs, 15 minutes before activity
☐ with all activity ☐ when the child fees he/she needs it

Yellow Zone: Caution – DO NOT LEAVE STUDENT UNATTENDED
Symptoms: Problems breathing – Cough, wheeze, or chest tight
Peak flow meter _____ to _____ (between 50% and 79% of personal best)

- If student is using quick relief inhaler > 2 times a week or requires frequent observation by school staff → **Notify** parents + school nurse.
- If student is coughing, wheezing and having difficulty breathing:
  ☐ Give ____ puffs of quick relief inhaler. May repeat in ____ minutes. → **Notify** parents and school nurse if repeated.
- If **NO** improvement after repeated dose, call 911 – see below.

Red Zone: CALL 911 and DO NOT LEAVE STUDENT UNATTENDED
Symptoms: Difficulty talking – Shortness of breath – Getting worse instead of better –
Blue appearance (lips/nails) – Medicine is not helping
Peak flow meter _____ (less than 50% of personal best)
☐ Give ____ puffs quick relief inhaler or nebulizer treatment and **notify** parents and school nurse.
☐ This student needs Epi auto-injector for severe asthma attacks and
☐ can carry and self-administer Epi auto-injector ☐ needs help giving the Epi auto-injector ☐ other _____

☐ Both the Healthcare Provider and the Parent/Guardian feel that the child has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

Special storage instructions: _____

Start date: _____ End date: _____

Healthcare provider

Name _____ Date _____ Phone _____ Signature _____

Student's name: _____ Birthdate: _____

II. Parent/Guardian's Section

I hereby request and give my permission for school district personnel to administer this prescribed medication to my child in accordance with the specific written orders from our medical provider. I do hereby release all school employees and the Board of Education from liability for damages, illness, or injury resulting from either performing or not performing any assistance requested.

I am responsible for the delivery of this medication to the school clinic and will notify the school immediately if we change our medical provider or the need for this medication is discontinued.

I understand this medication can only be administered to my child by a school nurse or myself until medically unlicensed staff in my child's school have completed the required District training. In the absence of a medically licensed person, such as a school nurse, only designated, trained staff are authorized to perform this task.

If this medication is required for extracurricular activities, I agree to provide a separate dose to school staff supervising my child's extracurricular activities

A new Asthma Action Plan and Orders form must be submitted each school year.

I understand that if any changes are needed on this Asthma Action Plan and Orders form, it is the parent's responsibility to contact the school nurse and submit a new form.

I understand that my child may be eligible for Section 504 plan.

I consent to communication between the prescribing health care provider or clinic, the school nurse, the school medical advisor and school-based health clinic providers as necessary for medical management.

Parent/Guardian signature Date

Home address Daytime phone