Asthma
Emergency Action Plan

Child's Name:	DOB:
Parent's Name:	Daytime Ph.No.: Cell:( )
	Daytime Ph.No.: Cell:( )
2nd Contact:	Daytime Ph.No.: Cell:( )
Doctor:	Office No.:
Teacher: Grade: Car#	School Nurse:
Category of Severity: Mild Mod. Severe	Personal Best Peak Flow (PF):

GREEN ZONE

If You See This:	Do This:
● Breathing is Good ● No Cough or Wheeze ● Can Work or Play	● May use rescue medication per physician's orders prior to PE, recess, sports or physical activity.
PF Above:	

YELLOW ZONE

If You See This:	Do This:
● Difficulty breathing (short inhalations with long exhalations) ● Mild wheezing ● Rapid, shallow breathing ● Excessive cough ● Flaring nostrils ● Child complains of chest tightness	● Attempt to calm student. ● Have child rest in a sitting position, breathing slowly through mouth, exhaling through pursed lips. ● Assist student in using rescue medication per physician/parent instructions. ● Notify parent of breathing difficulty and if medication is not effective within 15 minutes.
PF from: to:	

RED ZONE

If You See This:	Do This:
● No sign of improvement within 15 minutes after medication is administered. ● If Parent or emergency contact is unavailable. ● Student can't talk well ● Student is having extreme difficulty breathing or loses consciousness ● There is loss of color, pale/blue color noted around lips and/or nail beds	● **Repeat Rescue Medication per Medication Administration Orders** ● **Call 9-1-1**
PF Less than:	

<u>Controller Medication(s)</u> *(Medication(s) Kept At Home and Taken Daily)*

1. _____ 2. _____

3. _____ 4. _____

OVER>

PHYSICIAN TO COMPLETE:

Rescue Medications For Use at School

Medication (name): _____ Dose: _____

Directions for Administration: _____

ADDITIONAL INSTRUCTIONS:

1. **Known Asthma Triggers: _____**
2. **Activity Restrictions: _____**
3. **Approximately how often does this child have an acute asthma episode? _____**

A written statement, treatment plan and written emergency protocol developed by the student's health care provider must accompany the authorization forms for student who self carry and administer rescue medication in accordance with requirements stated in G.S. 115C-375.2. Standard forms for most common diagnosis may be obtained from school office or school nurse. Completion of this form for Asthma fulfills this requirement. All medications for use at school must be delivered by parent/guardian in a container properly labeled by a pharmacist with identifying information, (name of child, medication dispensed, dosage prescribed, and the time it is to be given or taken) or for OTC medications, in the manufacturer's labeled container.

_____ _____

Physician's Signature **Phone** **Date**

Parent Permission

I hereby give permission for my child (named above) to receive medication during school hours. A licensed physician has prescribed this medication to be administered during school hours; therefore, I hereby release Anderson Creek Academy Board, their agents and employees for all liability that may result from my child taking this medication. I consent for the medical provider to disclose health or medical information regarding the above prescribed medication. This information will be shared with any school staff members as deemed necessary unless you state otherwise. I agree to inform school staff of any change in my child's health status that would warrant change in this action plan. This consent is good for the current school year unless revoked in writing.

_____ _____

Parent / Guardian Signature **Phone** **Date**

Principal's Signature: _____ Date _____

Reviewed by: _____ Date _____

School Nurse