Kenai Peninsula Borough School District

STUDENT ASTHMA ACTION CARD

ID Photo

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)**

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*

1. **Med**_____**Dose**_____

2. **Med**_____ **Dose**_____

3. **Epinephrine Autoinjector will be used in the event of a severe asthma episode at school. This may be given in addition to the student's prescribed medication or if student does not have access to his/her prescribed medication.**

Dosage_____0.3mg OR _____0.15mg

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:** _____

Created by Asthma and Allergy Foundation of America, Alaska Chapter and the Alaska Asthma Coalition, October 2005. Revised 2012 KPBSD Health Services 8/2012

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

KPBSD STUDENT ASTHMA ACTION CARD *(continued)*

Student Name: _____ School_____ Student 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.)

☐ Exercise	☐ Chalk dust/dust	☐ Food _____
☐ Strong odors or fumes	☐ Carpets in the room	☐ Molds
☐ Respiratory infections	☐ Animals _____	☐ Latex
☐ Change in temperature	☐ Pollens (Spring/Summer/Fall)	☐ Other _____

• List all asthma medications taken each day.

	Name	Amount	When to Use
1.			
2.			
3.			

COMMENTS / SPECIAL INSTRUCTIONS

_____

_____

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 KPBSD 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. KPBSD 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: _____