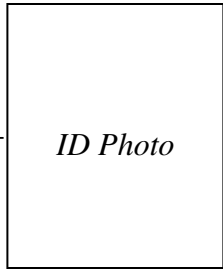


STUDENT ASTHMA ACTION CARD



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*

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:** _____

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

• List all asthma medications taken each day.

Table with 3 columns: Name, Amount, When to Use. Rows 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... It is recommended that backup medication be stored with the school/ school nurse...

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: _____