BIG WALNUT
LOCAL SCHOOL DISTRICT

Student:_____ Date of Birth_____School Year_____

Teacher:_____Grade level_____ Building: **BWE,P/S,GRE,SOU,PRE,BWIS,MS,HS**

Plan Updated on :____/____/____

Green Zone/Doing well	Name of Medicine (taken daily for control & maintenance)	How much to take	When to take
• no cough, wheeze, chest tightness, or shortness of breath during day or night • can do usual activities **My Asthma Triggers are:**_____ _____ __ My best peak flow is _____	1._____ 2._____ 3._____ 4._____	1._____ 2._____ 3._____ 4._____	1._____ 2._____ 3._____ 4._____

Before Exercise : __required __suggested __as needed	▢_____	▢ 2 or ▢4 puffs	5 minutes before exercise

Yellow Zone/ Asthma Symptoms Starting	**Do these things to help relieve your symptoms!**
• cough, wheeze, chest tightness or shortness of breath • waking at night due to asthma • can do some, but not all, usual activities	Medicine:_____ How much:_____ Frequency:_____ Route:_____ Medicine:_____ How much:_____ Frequency:_____ Route:_____ If symptoms do not go away or return in less than 4 hours • GET HELP (see orange or red zones) • CONTINUE taking green zone medicines

Orange: In Trouble	CALL For Help!
• Not improving or symptoms return too quickly • Cough, wheeze, chest tightness, fast breathing AFTER quick relief medicine • Relief from quick relief medicine doesn't last 4 hrs • Vomiting after coughing • Kept awake most of the night by asthma symptoms • Quick relief medicine is needed 4 or more times in a day	**Call Parents and EMS (911).** Name:_____ Number:_____ Medicine: Repeat_____ How much:_____ Frequency:_____ Route:_____ If you cannot reach the parent, you still need to call EMS (911)

RED ZONE/MEDICAL ALERT	GO For Help!
Not improving or symptoms return too quickly - ~having trouble breathing If you have ANY of these: • Rib and neck muscles show when breathing • Nose opens (flares) when breathing • Very short of breath • trouble walking & talking due to shortness of breath • lips or fingernails are blue • Quick-relief medicines have not helped • Cannot do usual activities	**Go to the closest ER or call 9-1-1 NOW!** **On the way also take the following medication(s):** Medicine:_____ How much:_____ Frequency:_____ Route:_____

✦Even if the parent/guardian can not be reached, DO NOT HESITATE to medicate as appropriate and/or call 911✦

Physician Signature:_____ Date:_____
Physician Printed Name:_____Phone Number:_____

Emergency Numbers

1. Doctor_____ Phone Number:_____

2. Emergency Contacts:

	Name	Relationship	Phone number (s)
a.	_____	_____	_____
b.	_____	_____	_____

I authorize an employee designated by the school board to administer the above medication. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. I also authorize the licensed healthcare professional to talk with the prescriber or pharmacist to clarify medication orders. I release and agree to hold the Board of Education, its officials and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization. Medication form must be received by the principal, his/her designee and/or the school nurse. I understand that the medication must be in the original container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration and the date of drug expiration when appropriate. This plan is effective for the above listed school year. It is the responsibility of Parent/Guardian to provide the school with a completed plan (signed by physician) at the start of each school year or as needed should any changes be made to the Asthma Action Plan. I authorize the asthma inhaler as prescribed at school and any school sponsored activity.

Parent's Signature:_____ Date:_____

Students who Self Carry Inhaled Asthma Medication (inhaler)

- ❏ Student is permitted Self Carry Inhaled Asthma Medication- Best practice recommends that a back up inhaler be kept in the office/clinic
- ❏ Yes, as the prescriber I have determined that the student is capable of possessing and using this inhaled medication appropriately and I have provided the student with training in the proper use of this medication. In the event that the inhaled medication is abused or misused by the student or others, school personnel have the authority to assume control of the inhaled medication.

_____ Date:_____

Physician Signature/Stamp