Asthma Action Plan

Loudoun County Public Schools

[To be completed by Health Care Provider]

Name ____________________ Date of Birth ____________ Teacher/Grade ____________

Parent/Guardian ____________________ HOME ____________ CELL ____________

Emergency Phone Number(s) ____________

Health Care Provider Name ____________________ Phone ____________ Fax ____________

Asthma Severity: ☐Intermittent ☐Mild Persistent ☐Moderate Persistent ☐Severe Persistent

Asthma Triggers: ☐Colds ☐Exercise ☐Animals ☐Dust ☐Smoke ☐Food ☐Weather ☐Other

If Feeling Well (Green Zone)

You have all of these:

- Breathing is good
- No cough or wheeze
- Can work/play
- Sleeping all night

Take Every Day: Long –Term Control Medications

MEDICINE:	HOW MUCH:	HOW OFTEN:	WHEN TO TAKE IT:

5-15 minutes before exercise use this medicine

If Not Feeling Well (Yellow Zone)

You have <u>any</u> of these:

- Cough
- Wheeze
- Tight Chest
- Coughing at night

Take Every Day Medications and ADD these Quick-Relief Medications

MEDICINE:	HOW MUCH:	HOW OFTEN:	WHEN TO TAKE IT:

Call doctor if these medicines are used more than two days a week.

If Feeling Very Sick (Red Zone)

Your asthma is getting worse fast:

- Medicine is not helping
- Breathing is hard and fast
- Nose opens wide
- Cannot talk or walk well
- Ribs show when breathing in

Take These Medicines and GET HELP from a Doctor NOW!

MEDICINE:	HOW MUCH:	HOW OFTEN:	WHEN TO TAKE IT:

SEEK EMERGENCY CARE or CALL 911 NOW if: Lips are bluish, getting worse fast, hard to breathe, can't talk or cry because of hard breathing or child has passed out

I have instructed this student in the proper use of his/her medications. It is my professional opinion that he/she should be allowed to carry and use this medication by him/herself. ☐YES ☐NO

In my professional opinion, this student should not carry his/her medication and it should be stored in the health office. ☐YES ☐NO

I give permission for school personnel to follow this plan, administer medication and care for my child and contact my health care provider if necessary. I assume full responsibility for providing the school with the prescribed medication.

Health Care Provider Signature/Date ____________________ Parent Signature/Date ____________________

Loudoun County Public Schools
Asthma Individual Health Care Plan

Student's Name______________________________ **Date of Birth** _______

Teacher's Name______________________________ **Grade** ____________

Symptoms of an asthma attack might include:

Coughing	Gasping for air
Wheezing	Color changes (pale or blue)
Tightness in chest	Child states "difficulty breathing"

Other____

If symptoms of an attack are present or ___________ states that he/she feels an attack coming on:

a. **DO NOT SEND STUDENT TO CLINIC ALONE.**
b. If student cannot walk or talk in complete sentences, then the teacher should contact the clinic.
c. Have student sit upright and sip water.
d. Administer prescribed medication by inhaler or nebulizer.
e. Reassure student and attempt to keep him/her calm and breathing slowly and deeply.
f. Student should respond to treatment within 15-20 minutes.
g. If no change, then contact the parent.
h. **IF STUDENT'S BREATHING BECOMES SIGNIFICANTLY WORSE, CALL 911:**
    - Shoulders kept raised
    - Beaded perspiration
    - Blue lips, fingernails, or skin
    - Labored breathing
    - Pale
    - Skin between ribs or at base of neck collarbone retracts as student breathes

Individual Considerations

☐ Self pace for physical activities
☐ Inhaler before physical activities
☐ Physician approval for student to carry inhaler
☐ Restrictions ordered by physician: ______________________________
☐ Other (Specify, i.e. recent hospitalization or ER visit):______________________

Bus

Transportation will be alerted to student's asthma.
The student will carry an inhaler on the bus per physician order: ☐YES ☐NO
An inhaler can be found in: ☐Backpack ☐waist pack ☐other_______________

Additional accommodations should be discussed with school nurse or resource nurse.

______________________________ ______________________________
Parent Signature/Date School Nurse or Resource Nurse/Date

Loudoun County Public Schools
Parent/Student Agreement for Permission to Carry an Inhaler

(Physician must also sign that student should carry an inhaler at school on the Asthma Action Plan)

Parent:

- I give my consent for my child to carry and self-administer his/her inhaler.
- I understand that the school board or its employees cannot be held responsible for negative outcomes resulting from self-administration of the inhaled asthma medication.
- This permission to possess and self-administer asthma medication may be revoked by the principal if it is determined that your child is not safely and effectively self-administering the medication.
- A new Asthma Action Plan signed by the physician and Parent/Student Agreement for Permission to Carry an Inhaler must be submitted each school year.

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Parent/Guardian's Signature Required *Date*

Student:

- I have demonstrated the correct use of the inhaler to the school nurse/health clinic assistant.
- I agree never to share my inhaler with another person or use it in an unsafe manner.
- I agree that if there is no improvement after self-administering the medication, I will report to the school nurse/health clinic assistant or another appropriate adult if the nurse/health clinic assistant is not available or present.

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Student's Signature Required *Date*