# 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:** _____

Created by Asthma and Allergy Foundation of America, Alaska Chapter and the Alaska Asthma Coalition, October 2005. Revised 2012

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

**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 the school district 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. The school district 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: _____**

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