River Falls School District – Asthma Action Plan

A prescription medication may be administered to a student in compliance with written instructions of practitioner and written consent from parent/guardian. All prescription medications need to come to school in the original pharmacy-labeled package: student name, prescriber name, drug, dose, effective date, and directions in legible format. Health Services cannot administer expired medication and/or medication that is not in original pharmacy-labeled package. Health Services requires the practitioner to discontinue medication. Asthma Action Plan needs to be renewed each school year or if medication orders change during the school year. It is recommended that a back-up inhaler be stored in the school health office if the student is self-carrying medication.

Student Name _____ DOB _____ Grade_____ School_____

Contact 1 Parent/Guardian _____ C _____ W_____

Contact 2 Parent/Guardian _____ C _____ W_____

Triggers: ☐Colds ☐Smoke ☐Weather ☐Exercise ☐Dust ☐Air Pollution ☐Animals ☐Food ☐Other _____

GREEN ZONE: DOING WELL **Controller medication: Take these everyday**

Symptoms:	**Medicine**	**How much**	**How Often**
Breathing is good			
No cough or wheeze			
Can work/play easily			

Pre-exercise medication

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YELLOW ZONE: GETTING WORSE **Use rescue (fast-acting) medicine:**

Symptoms:	**Medicine**	**How much**	**How Often**
It's hard to breathe			
Cough, wheeze or chest tight			
Problems working or playing	**School staff directions:**		
Waking coughing at night	Notify school health office. Remove student from any obvious trigger and escort student to health office.		
	DO NOT leave the student alone.		
	Sit student comfortably leaning forward.		
	Give initial treatment of rescue medicine and allow for rest. *If no improvement after* _____ *minutes, give:*		
	Medicine	**How much**	**How Often**
	_____		
	Contact parent/guardian to make aware of asthma episode and effectiveness of treatment.		
	An asthma emergency is indicated by no response to initial treatment or worsening of symptoms.		

RED ZONE: ASTHMA EMERGENCY **Use rescue (fast-acting) medicine NOW:**

Symptoms:	**Medicine**	**How much**	**How Often**
Lots of trouble breathing			
Cannot work or play			
Nostrils open wide	**School staff directions:**		
Ribs are showing	Call **911.**		
Pale and/or sweating	Call parent/guardian NOW regarding severity of student's asthma episode.		
Medicine is not helping	DO NOT leave the student alone.		
Trouble walking or talking	Sit student comfortably leaning forward.		
Lips or fingernails are gray or blue			

☐ Check box if: *Student **may** carry and self-administer rescue medicine while at school. Student understands asthma signs/symptoms and has successfully demonstrated inhaler delivery.*

Practitioner Signature _____ **Practitioner Name**_____ **Date** _____

School Year _____ **Address** _____ **Phone**_____

"Practitioner" means any physician, dentist, optometrist, physician assistance, advanced nurse prescriber, or podiatrist licensed in any state.

Parent/Guardian Signature _____ Date _____

I request that the above mentioned medication be given as prescribed by the practitioner to my child. I will keep River Falls School District aware of any changes in medication profile or health concern of my child. I give my medical provider and River Falls School District permission to release and obtain information from each other as necessary to administer medication. I understand medication will be disposed of if not picked up within one week following termination of the order, or one week beyond the close of school.