STUDENT ASTHMA ACTION CARD

Name _____ **Birthdate** _____ **Teacher** _____

School Nurse _____ **Phone** _____ **Fax** _____

Healthcare Provider treating student for Asthma _____ **Phone** _____

Preferred Hospital_____ **Personal Best Peak Flow Reading** _____

Green Zone: All Clear

- **Breathing is easy. No asthma symptoms with activity or rest.**
- **Peak Flow Range: _____ to _____ (80%-100% of personal best) *If applicable.***

☐ **Pre-medicate if needed 10-20 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%-80% of personal best) *If applicable.***
- **Medicate with quick reliever. Give medications as listed below.**
- **May re-check peak flow in 15-20 minutes.**
- **Student should respond to treatment in 15-20 minutes and return to Green Zone, if not, contact parent.**

Red Zone: Emergency Plan

- **Call EM-911 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 waling 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 15-20 minutes.**
- **Student should respond to treatment in 15-20 minutes.**
- **Contact parent or guardian.**

EMERGENCY ASTHMA MEDICATIONS—*To be completed by Healthcare Provider*

1. **Med** _____ **Dose** _____
2. **Med** _____ **Dose** _____

Authorization by Healthcare Provider:

☐ **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.**

***Healthcare Provider Signature*: _____ Date _____**

Anchorage School District
Nursing & Health Services

Created by Asthma and Allergy Foundation of America, Alaska Chapter and the Alaska Asthma Coalition, October 2005. ***Revised 9/2011***

STUDENT ASTHMA ACTION CARD

DAILY ASTHMA MANAGEMENT PLAN *Side 2, Continued:* TO BE COMPLETED BY PARENT/GUARDIAN AND STUDENT

Student Name: _____ Birthdate _____

- **Identify the things which start an asthma episode (if known) Check all that apply. These should be excluded from the student's environment as much as possible.**

☐	**Exercise**	☐	**Chalkdust/ Dust**	☐	**Food _____**
☐	**Strong Odors or Fumes**	☐	**Carpets in Room**	☐	**Molds**
☐	**Respiratory Infections**	☐	**Animals _____**	☐	**Latex**
☐	**Change in Temperature**	☐	**Pollens Spring/Summer/Fall**	☐	**Other:**

- **List all asthma medications taken each day (including at home).**

	Name	***Amount***	***When to Use***
1.			
2.			
3.			

- **Comments and Special Instructions**

_____

_____

AUTHORIZATIONS:

PARENT/GUARDIAN:

☐ I want this plan to be implemented for my child at school

☐ I authorize my child to carry and self-administer asthma medications and I agree to release ASD and school personnel from all claims of liability if my child suffers any adverse reactions from self-administration and/or storage of asthma medication. ☐ **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 healthcare provider regarding the asthma condition and the prescribed medication regimen.

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 medications with me at all times.

☐ I will not share them or use my asthma medications for any other use than what it is meant for.

Student Signature_____ Date _____

☐ Approved by School Nurse/School Principal. Back up medication is stored at school ☐ Yes ☐ No

School Nurse/School Principal Signature _____ Date _____

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