

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		
	_____	_____	_____

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	_____	_____	_____
Waking coughing at night	_____	_____	_____
	School staff directions:		
	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. <i>If no improvement after _____ minutes, give:</i>		
	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	_____	_____	_____
Ribs are showing	_____	_____	_____
Pale and/or sweating	_____	_____	_____
Medicine is not helping	_____	_____	_____
Trouble walking or talking	_____	_____	_____
Lips or fingernails are gray or blue	_____	_____	_____
	School staff directions:		
	Call 911 .		
	Call parent/guardian NOW regarding severity of student's asthma episode.		
	DO NOT leave the student alone.		
	Sit student comfortably leaning forward.		

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.