NEW MEXICO ASTHMA ACTION PLAN FOR SCHOOLS

Date_____

School District _____ School Name _____

School Nurse / Health Asst. _____ School Phone # / FAX # _____ / _____

PARENT/GUARDIAN: Please complete the information in the top sections and sign consent at bottom of the page.

Student Name	Date of Birth	Student #
* Health Care Provider Name/Title	Provider's Office Phone / FAX #	
Parent/Guardian	Parent's Phone #s	
Emergency Contact	Contact Phone #s	
Allergies to Medications:		

GREEN means Go!
Use CONTROL medicine daily

YELLOW means Caution!
Add Rescue medicine

RED means EMERGENCY!
Get help from a provider now!

Asthma Triggers Identified (Things that make your asthma worse):
☐ Exercise ☐ Colds ☐ Smoke (tobacco, fires, incense) ☐ Pollen ☐ Dust
☐ Strong Odors ☐ Mold/moisture ☐ Stress/Emotions ☐ Pests (rodents, cockroaches)
☐ Gastroesophogeal reflux ☐ Season: Fall, Winter, Spring, Summer
☐ Animals_____ ☐ Other (*food allergies*):_____

Date of student's **last visit to medical provider:** ____/____/____

Date of Last Flu Shot ____/____/____

Inhaler is kept:
☐ With Student
☐ In Classroom
☐ Health Office
☐ Other_____

HEALTH CARE PROVIDER: Please complete Severity Level, Zone Information and Medical Order Below

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

Green Zone: Go! Take Control Medications EVERY DAY

You have ALL of these:
- Breathing is easy
- No cough or wheeze
- Can work and play
- No symptoms at night

Peak flow (optional):
Greater than ≥ _____
(More than 80% of Personal Best)

Personal best peak flow: _____

☐ No controller medication is prescribed. Always rinse mouth after using your daily inhaled medication.

☐ _____, _____ puff(s) MDI with spacer _____ times a day
Inhaled corticosteroid or inhaled corticosteroid/long-acting β-agonist

☐ _____, _____ nebulizer treatment(s) _____ times a day
Inhaled corticosteroid

☐ _____, take _____ by mouth once daily at bedtime
Leukotriene antagonist

For asthma with exercise, ADD:
☐ _____, _____ puff(s) MDI with spacer 5 to 15 minutes before exercise

For nasal/environmental allergy, ADD:
☐ _____

Yellow Zone: Caution! Continue CONTROL Medicine & ADD RESCUE Medicines-

You have ANY of these:
- Cough or mild wheeze
- Tight chest
- First signs of a cold
- Problems sleeping, Playing or working

Peak flow (optional):
_____ to _____
(50% - 80% of Personal Best)

DO NOT LEAVE STUDENT ALONE! Call Parent/Guardian when rescue medication is given.

☐ _____, _____ puff(s) MDI with spacer & every_____ hours as needed
Fast-acting inhaled β-agonist

OR

☐ _____, _____ nebulizer treatment(s) & every_____ hours as needed
Fast-acting inhaled β-agonist

☐ Other _____

Call your MEDICAL PROVIDER if you have these signs more than two times a week, or if your rescue medicine does not work! If symptoms are NOT better OR peak flow is NOT improved, go to RED ZONE↓

Red Zone: EMERGENCY! Continue CONTROL Medicine & ADD RESCUE Medicines and GET HELP!

You have ANY of these:
- Cannot talk, eat, or walk well
- Medicine is not helping or
- Getting worse, not better
- Breathing hard & fast
- Blue lips & fingernails

Peak flow (optional):
Less than ≤ _____
(Less than 50% of Personal Best)

DO NOT LEAVE STUDENT ALONE! → Call for emergency 911 and start treatment

☐ _____, _____ puff(s) MDI with spacer & every 20 minutes until paramedics arrive
Fast-acting inhaled β-agonist

OR

☐ _____,_____ _____ nebulizer treatment(s) every 20 minutes until paramedics arrive
Fast-acting inhaled β-agonist

Call 911 and start treatment immediately. Then call Parent/Guardian.

☐ Oxygen _____l/min (If available in Health Office) ☐ 0_2 Sat. / time _____

HEALTH CARE PROVIDER ORDER AND SCHOOL MEDICATION CONSENT

Check all that apply:

____ Student has been instructed in the proper use of his/her asthma medications and IS ABLE TO CARRY AND SELF-ADMINISTER his/her INHALER AT SCHOOL

____ Student is to notify designated school health personnel after using inhaler at school.

____ Student needs supervision or assistance when using inhaler.

____ Student is unable to carry his/her inhaler while at school.

* SIGNATURE/TITLE_____DATE_____

Parent/Guardian:

I approve of this asthma action plan. I give my permission for the school nurse and trained school personnel to follow this plan, administer medication(s), and contact my provider, if necessary. I assume full responsibility for providing the school with the prescribed medications and delivery and monitoring devices. I give my permission for the school to share the above information with school staff that need to know and permission for my child to participate in any asthma educational learning opportunities at school.

SIGNATURE: _____ DATE: _____

SCHOOL NURSE: _____ DATE: _____