

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 #	Date of last medical exam: ____/____/____	Inhaler is kept: <input type="checkbox"/> with student <input type="checkbox"/> Health Office <input type="checkbox"/> Classroom <input type="checkbox"/> Other: _____
*Health Care Provider Name/Title	Provider's Office Phone / FAX #			
Parent/Guardian	Parent's Phone #s			
Emergency Contact	Contact Phone #s		Date of last Flu Shot: ____/____/____	Inhaler expires on: ____/____/____
Allergies to Medications:				

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

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

Asthma Severity: Intermittent or Persistent: Mild Moderate Severe

Green Zone: Go - You're Doing Well! Take Control Medications EVERYDAY to Prevent Symptoms

You have ALL of these: <ul style="list-style-type: none"> Breathing is easy No cough or wheeze Can work and play Sleep through the night 	<input type="checkbox"/> No controller medication is prescribed. <input type="checkbox"/> _____, _____ puff(s) MDI with spacer _____ times a day <small>Inhaled corticosteroid or inhaled corticosteroid/long-acting β-agonist</small> <input type="checkbox"/> _____, _____ nebulizer treatment(s) _____ times a day <small>inhaled corticosteroid</small> <input type="checkbox"/> _____, take _____ by mouth once daily at bedtime <small>Leukotriene antagonist</small> <small>Always rinse mouth after using your daily inhaled medication.</small> For asthma with exercise, ADD: <input type="checkbox"/> _____, _____ puff(s) MDI with spacer 5 to 15 minutes before exercise <p style="text-align: center; color: green;">Inhalers work better with spacers. Always use a mask when prescribed.</p>
Peak Flow may be useful for some students.	

Yellow Zone: Slow Down! Continue Green Zone Medicine & ADD RESCUE Medicines-

You have ANY of these: <ul style="list-style-type: none"> First signs of a cold Cough or mild wheeze Exposure to known trigger Problems sleeping, playing, or working Cough at night 	DO NOT LEAVE STUDENT ALONE! Call Parent/Guardian when rescue medication is given. <input type="checkbox"/> _____, _____ puff(s) MDI with spacer & every _____ hours as needed <small>Fast-acting inhaled β-agonist</small> OR <input type="checkbox"/> _____, _____ nebulizer treatment(s) & every _____ hours as needed <small>Fast-acting inhaled β-agonist</small>
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Red Zone: DANGER – Get Help! TAKE THESE MEDICINES NOW AND GET MEDICAL HELP NOW!

Your asthma is getting worse fast: <ul style="list-style-type: none"> Cannot talk, eat, or walk well Medicine is not helping or Getting worse, not better Breathing hard & fast Blue lips & fingernails 	DO NOT LEAVE STUDENT ALONE! Call 911 and start treatment then call Parent/Guardian. <input type="checkbox"/> _____, _____ puff(s) MDI with spacer every _____ minutes until EMS arrives <small>Fast-acting inhaled β-agonist</small> <input type="checkbox"/> For schools with 02: (Only use Oxygen if Pulse Oximeter available) Give O2 to keep sat. above 92% unless otherwise contraindicated. Check sat. continually until EMS arrives.
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✓ *Make an appointment with your doctor within two days of an emergency visit, hospitalization, or anytime for ANY problem or question about asthma*

School Nurse: Call provider for control concerns or if rescue medication is used more than 2 times per week for asthma symptoms

Parents: Call your child's doctor for control concerns or if rescue medication is used more than 2 times per week for asthma symptoms

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, and share this plan with the SBHC, if applicable. I assume full responsibility for providing the school with the prescribed medications and delivery of 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: _____