Asthma Action Plan for Home and School

AMERICAN LUNG ASSOCIATION®

Name _____ DOB ____/____/_____

Severity Classification ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Asthma Triggers (list) _____

Peak Flow Meter Personal Best ____

Green Zone: Doing Well

Symptoms: Breathing is good – No cough or wheeze – Can work and play – Sleeps well at night
Peak Flow Meter _____ (more than 80% of personal best)

Control Medicine(s)	Medicine	How much to take	When and how often to take it	Take at
	_____	_____	_____	☐ Home ☐ School
	_____	_____	_____	☐ Home ☐ School

Physical Activity ☐ Use albuterol/levalbuterol ____ puffs, 15 minutes before activity ☐ with all activity ☐ when the child feels he/she needs it

Yellow Zone: Caution

Symptoms: Some problems breathing – Cough, wheeze, or chest tight – Problems working or playing – Wake at night
Peak Flow Meter _____ to _____ (between 50% and 79% of personal best)

Quick-relief Medicine(s) ☐ Albuterol/levalbuterol ____ puffs, every 4 hours as needed

Control Medicine(s) ☐ Continue Green Zone medicines

☐ Add _____ ☐ Change to _____

The child should feel better within 20–60 minutes of the quick-relief treatment. If the child is getting worse or is in the Yellow Zone for more than 24 hours, THEN follow the instructions in the RED ZONE and call the doctor right away!

Red Zone: Get Help Now!

Symptoms: Lots of problems breathing – Cannot work or play – Getting worse instead of better – Medicine is not helping
Peak Flow Meter _____ (less than 50% of personal best)

Take Quick-relief Medicine NOW! ☐ Albuterol/levalbuterol ____ puffs, _____ (how frequently)

Call 911 immediately if the following danger signs are present
- Trouble walking/talking due to shortness of breath
- Lips or fingernails are blue
- Still in the red zone after 15 minutes

School Staff: Follow the Yellow and Red Zone instructions for the quick-relief medicines according to asthma symptoms.
The only control medicines to be administered in the school are those listed in the Green Zone with a check mark next to "Take at School".

☐ **Both the Healthcare Provider and the Parent/Guardian** feel that the child has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

Healthcare Provider

Name _____ Date _____ Phone (_____) _____-_____ Signature _____

Parent/Guardian

☐ I give permission for the medicines listed in the action plan to be administered in school by the nurse or other school staff as appropriate.
☐ I consent to communication between the prescribing health care provider or clinic, the school nurse, the school medical advisor and school-based health clinic providers necessary for asthma management and administration of this medicine.

Name _____ Date _____ Phone (_____) _____-_____ Signature _____

School Nurse

☐ The student has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

Name _____ Date _____ Phone (_____) _____-_____ Signature _____

Please send a signed copy back to the provider listed above.

LaSalle-Peru Township High School
School Medication Authorization Form

To be completed by the child's parent(s)/guardian(s). A new form must be completed every school year. Keep in the school nurse's office, or, in the absence of a school nurse, the Building Principal's office.

Today's Date: _____

Student's Name: _____ Birth Date: _____

Address: _____

Home Phone: _____ Emergency Phone: _____

Year in School (circle): Freshman Sophomore Junior Senior

To be completed by the student's physician, physician assistant, or advanced practice RN.
*(**Note**: for asthma inhalers only, use the "Asthma Inhalers" section).*

Physician's Printed Name: _____

Office Address: _____

Office Phone: _____ Emergency Phone: _____

Medication Name: _____

Purpose: _____

Dosage: _____ Frequency: _____

Time medication is to be administered or under what circumstances:

_____

Prescription Date: _____ Order Date: _____ Discontinuation Date: _____

Diagnosis requiring medication: _____

Is it necessary for this medication to be administered during the school day? ____ Yes _____ No

Will student be allowed to self-administer this medication? _____ Yes _____ No

Expected side effects, if any: _____

Time interval for re-evaluation: _____

Other medications student is receiving: _____

_____
Physician's Signature Date

Asthma Inhalers *Parent(s)/Guardian(s) please attach prescription label here:*

For only parent(s)/guardian(s) of students who need to carry asthma medication or an epinephrine auto-injector:

I authorize LaSalle-Peru Township High School District 120, hereafter LPHS, and its employees and agents, to allow my child or ward to carry and self-administer his or her asthma inhaler and/or use his or her epinephrine auto-injector: (1) while in school, (2) while at a school-sponsored activity, (3) while under the supervision of school personnel, or (4) before or after normal school activities, such as while in before-school or after-school care on school-operated property. Illinois law requires LPHS to inform parent(s)/guardian(s) that it, and its employees and agents, incur no liability, except for willful and wanton conduct, as a result of any injury arising from a student's self-administration or medication or epinephrine auto-injector (105 ILCS 5/22-30).

If you agree please initial: _____
Parent/Guardian

For all parent(s)/guardian(s):

By signing below, I agree that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize the LPHS and its employees and agents, in my behalf, to administer or to attempt to administer to my child (or to allow my child to *self-administer* pursuant to State law, while under the supervision of the employees and agents of LPHS), lawfully prescribed medication in the manner described above. **I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse and specifically consent to such practices**, and

I agree to indemnify and hold harmless the School District and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration or the child's self-administration of medication.

_____
Parent(s)/Guardian(s) Printed Name

Address (if different from Student's above): _____

Phone: _____ Emergency Phone: _____

_____ _____
Parent(s)/Guardian(s) Signature Date