NIAGARA FALLS CITY SCHOOL DISTRICT
Health Services Asthma Action Plan

Date Completed

Name	Date of Birth	Grade/Teacher
Health Care Provider	Health Care Provider's Office Phone	Medical Record Number
Parent/Guardian	Phone	Alternate Phone
Parent/Guardian/Alternate Emergency Contact	Phone	Alternate Phone

DIAGNOSIS OF ASTHMA SEVERITY

☐ Intermittent ☐ Persistent [◯ Mild ◯ Moderate ◯ Severe]

ASTHMA TRIGGERS (Things That Make Asthma Worse)

☐ Smoke ☐ Colds ☐ Exercise ☐ Animals ☐ Dust ☐ Food
☐ Weather ☐ Odors ☐ Pollen ☐ Other ____________

GREEN ZONE: GO!

Take These **DAILY CONTROLLER MEDICINES (PREVENTION)** Medicines **EVERY DAY**

You have ALL of these:

- Breathing is easy
- No cough or wheeze
- Can work and play
- Can sleep all night

☐ No daily controller medicines required

☐ Daily controller medicine(s):______________________________ **TO BE TAKEN AT HOME ONLY**

☐ ____

Take_____puff(s) every _____ hour. If no improvement may repeat after ____ minutes

☐ For asthma with exercise, Take ____ puff(s) ___ with ___without spacer ____ minutes before exercise

ALWAYS RINSE YOUR MOUTH AFTER USING YOUR DAILY INHALED MEDICINE.

YELLOW ZONE: CAUTION!

Continue **DAILY CONTROLLER MEDICINES** and **ADD QUICK-RELIEF** Medicines

You have ANY of these:

- Cough or mild wheeze
- Tight chest
- Shortness of breath
- Problems sleeping, working, or playing

Take daily controller medicine if ordered and add this quick-relief medicine when you have breathing problems:

☐ ____ inhaler______mcg

Take_____puffs every_____hours, ___with ____ without spacer

☐ ____ nebulizer______mg /______ml

Take a ______________________________ nebulizer treatment every ______ hours, *if needed.*

☐ Other ____

If quick-relief medicine does not HELP within______minutes, take it again and CALL your Health Care Provider

If using quick-relief medicine more than______times in______hours, CALL your Health Care Provider

IF IN THE YELLOW ZONE MORE THAN 24 HOURS, CALL HEALTH CARE PROVIDER.

RED ZONE: EMERGENCY!

Continue **DAILY CONTROLLER MEDICINES** and **QUICK-RELIEF** Medicines and **GET HELP!**

You have ANY of these:

- Very short of breath
- Medicine is not helping
- Breathing is fast and hard
- Nose wide open, ribs showing, can't talk well
- Lips or fingernails are grey or bluish

☐ ____inhaler_______mcg

Take_____puffs every_______hours, _____with _______ without spacer

☐ ____ nebulizer______mg /______ml

Take a______________________________nebulizer treatment every______hours, *if needed.*

☐ Other ____

CALL HEALTH CARE PROVIDER AGAIN WHILE GIVING QUICK-RELIEF MEDICINE. If health care provider cannot be contacted, CALL 911 FOR AN AMBULANCE OR GO DIRECTLY TO THE EMERGENCY DEPARTMENT!

REQUIRED Health Care Provider PERMISSIONS FOR ALL MEDICATION USE AT SCHOOL

I request this plan to be followed as written. This plan is valid for the school year **September 7, 2021-- July 1, 2022**.

I attest that this student has demonstrated to me that they can self-administer this rescue medication effectively and may carry and use this medication independently at school with no supervision by school personnel. _______ YES ________ NO

Signature____Date ________________

REQUIRED Parent/Guardian PERMISSIONS FOR ALL MEDICATION USE AT SCHOOL

I give consent for the school nurse to give the medications listed on this plan or for trained school staff to assist my child to take them after review by the school nurse. This plan will be shared with school staff who care for my child.

I agree my child can self-administer this rescue medication effectively and may carry and use this medication independently at school with no supervision by school personnel. _______ YES _______ NO

Signature____Date ________________