

MIDVIEW LOCAL SCHOOL DISTRICT ASTHMA ACTION PLAN

Dear Parent/Guardian:

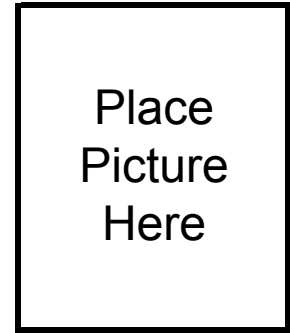
Your child's school health records indicate that they have asthma. In order for us to care for your child during an asthmatic episode we need to have an Asthma Action plan completed. Please have your physician complete and sign the attached Asthma Action Plan for your child and return it to the school with any asthma medication that may be needed. Please feel free to contact me with any questions or concerns you may have at 748-5302.

All paper work and medication must be in place prior to the start of the school year.

Thank you,
JoAnne Ferritto, R.N.
Midview School Nurse

Asthma Action Plan - Midview Local School District

Name _____ Building _____
 Teacher _____ Grade _____
 Parent/Guardian _____ Phone:(h) _____
 Phone:(w) _____
 Parent/Guardian _____ Phone:(h) _____
 Phone:(w) _____



Physician Treating Student for Asthma: _____ Ph: _____

Physician Signature _____ Date _____ Fax: _____

Check all that apply

Student is competent and responsible to self-carry and self-administer medication independently.

TRIGGERS Mold/pollens Animals Colds Dust Exercise Smoke Weather Fragrance

GREEN ZONE: Doing Well

Symptoms	Action
+ Breathing is good + No cough or wheeze + Can work and play + Sleeps all night + No early warning signs	Controller medications given at home as prescribed by MD <input type="checkbox"/> Pre-medicate for physical activity with <div style="text-align: center;">Medication/dose/frequency</div> <input type="checkbox"/> Prior to Gym <input type="checkbox"/> Prior to Recess

YELLOW ZONE: Getting Worse

Symptoms	Action
+ Cough, wheeze, chest tight + Problems working/playing + Early warning Signs + Shortness of Breath	Take quick relief Medication <div style="text-align: center;">Medication/dose/frequency</div> <input type="checkbox"/> If symptoms do not improve after _____ minutes: repeat quick relief medication again, call parents and School RN <input type="checkbox"/> If symptoms do not improve after the medication is repeated: Call EMS (911), School RN, And Parents <input type="checkbox"/> If symptoms get worse at anytime: Call EMS (911), School RN, And Parents

■ Report frequent use of quick relief medications twice a day for 3 days, (not for exercise) to the School RN and Parents

RED ZONE: Medical Alert

Symptoms	Action
+ Cannot stop coughing + Breathing fast + Flaring nostrils + Medication not helping/getting worse, instead of better + Trouble walking or talking from shortness of breath + The skin between the ribs and above the collarbone pulls in or retracts + Lips or fingernails are blue	School Actions: <input type="checkbox"/> Call EMS (911) IMMEDIATELY <input type="checkbox"/> Give quick-reliever medication and continue every 15 minutes until EMS(911) ARRIVES <input type="checkbox"/> Call School RN and Parents

I hereby give my consent to any employee of the Midview School Board, who has been duly authorized by the Board, to administer, to my child, the medications as prescribed above by their physician. I also, agree to deliver the medication to the school in it's original container and clearly labeled with my child's name.

Parent/Guardian's Signature _____ Date _____