Asthma Action Plan

(To be completed by Doctor/Nurse)

Name | Birth Date | Effective Date

School | Parent/Guardian | Parent's Phone

Doctor/Nurse's Name | Doctor/Nurse's Office Phone

Emergency Contact After Parent | Contact Phone

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

Asthma Triggers: ☐ Colds ☐ Exercise ☐ Animals ☐ Dust ☐ Smoke ☐ Food ☐ Weather ☐ Other: _____

TAKE THESE MEDICINES EVERYDAY

Child feels good:

- Breathing is good
- No cough or wheeze
- Can work/play
- Sleeps all night

Peak flow in this area:

_____to_____

MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

Green

20 MINUTES BEFORE EXCEPTION USE THIS MEDICINE:

IF NOT FEELING WELL — TAKE EVERYDAY MEDICINES AND ADD THESE RESCUE MEDICINES

Child has *any* of these:

- Cough
- Wheeze
- Tight Chest

Peak flow in this area:

_____to_____

MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

Yellow

Call your doctor/nurse's office if the symptoms don't improve in 2 days OR if the flare lasts for longer than ___ days. After _____ days go back to GREEN ZONE and take everyday medications as instructed.

IF FEELING VERY SICK CALL THE DOCTOR OR NURSE NOW! — TAKE THESE MEDICINES

Child has *any* of these:

- Medicine not helping
- Breathing is hard and fast
- Lips and fingernails are blue
- Can't walk or talk well

Peak flow below:

_____

MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

Red

IF UNABLE TO CONTACT YOUR DOCTOR OR NURSE:
Call 911 or go to the nearest emergency room and bring this form with you!

I give permission to the doctor, nurse, health plan, and other health care providers to share information about my child's asthma to help improve the health of my child.

Parent/Guardian Signature | Date

Health Care Provider Signature

Adapted from the NYC Childhood Asthma Initiative

Adapted from the NHLBI

Printed 2004

To download additional forms go to: www.hpcpa.org

Pine Grove Area School District

Promoting, Growth, Achievement, Success, and Direction for ALL Children!

SCHOOL HEALTH SERVICES

2019-2020 School Year

Medication Order

It is this school district's policy to request that medications be given before or after school hours. When this is not possible, prior to receiving the medication (prescription or non-prescription) at school, each student must provide the school nurse with a Medication Order signed by a licensed prescriber and the student's parent/guardian.
All medications must be in the original container. This form is valid only for the current school year.

Name of Student _____ Date of Birth _____

Medical Problems _____ Allergies _____

Name of Medication _____ Dosage _____ Route _____

Diagnosis / Reason for Taking _____ Frequency / Time of Administration _____ Discontinuation Date _____

Specific Directions_____

☐ Student may carry and self-administer EpiPen ☐ Student may carry and self-administer inhaler

Additional Information (Serious reactions, side effects, contraindications, etc.) _____

Other Medications Currently Taking _____

Licensed Prescriber's Signature _____ Date _____

Licensed Prescriber's Name Printed _____ Licensed Prescriber's Phone Number _____

I give permission for the above medication to be given to my child during school hours. I understand that the medication will be given according to my child's licensed prescriber's directions. I do hereby release, discharge, and hold harmless the Pine Grove Area School District, its agents and its employees from any and all liability and claim whatsoever for the administration of the above medication to the above named child.

Signature of Parent/Guardian _____ Date _____

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SCHOOL HEALTH SERVICES

2019-2020 School Year
Asthma Inhaler Contract

Name of Student _____ Date of Birth _____

I give permission for my child to carry and administer their inhaler. Thus, the school is not responsible for ensuring the medication is taken. The school district and its employees are relieved of any responsibility for the benefits or consequences of the inhaler.

Signature of Parent/Guardian _____ Date _____

I have received and understand the instructions from my physician/CRNP/PA on proper safety precautions for the handling and disposal of my inhaler and agree to abide by the following rules:
I will follow the directions for the use of my inhaler as ordered by my physician/CRNP/PA.
I will never allow another student to have access to my inhaler.
I will notify the school nurse each time I use my inhaler.
I understand that if I do not follow these rules, I will lose the privilege to carry my inhaler.

Signature of Student _____ Date _____

The above named student has demonstrated the ability to correctly self-administer his/her prescribed asthma inhaler.

Signature of School Nurse _____ Date _____