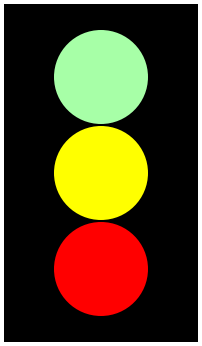
School District of Washington
Asthma Action Plan



Name:		Date:
Birth Date:	Provider Phone #:	Fax #:
School:	Grade/Teacher:	
Important! Things that make your asthma worse (Triggers): □ dust □ pets □ mold □ smoke □ pollen □ colds/viruses □ other _____		

Severity: □ Severe Persistent □ Moderate Persistent □ Mild Persistent □ Mild Intermittent

GO – You're Doing Well! Use these medicines everyday:

PERSONAL BEST PEAK FLOW: _____

You have *all* of these:
- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work and play

OR

Peak flow from _____ to _____

MEDICINE	HOW MUCH	HOW OFTEN/WHEN
_____	_____ Puffs _____ Tabs _____ Nebulizer	_____ Xs per day AM PM
_____	_____ Puffs _____ Tabs _____ Nebulizer	_____ Xs per day AM PM

CAUTION – Slow Down! Continue with green zone medicine and add:

You have *any* of these:
- First signs of a cold
- Exposure to known trigger
- Cough
- Mild wheeze
- Tight chest
- Coughing at night

OR

Peak flow from _____ to _____

MEDICINE	HOW MUCH	HOW OFTEN/WHEN
_____	_____ Puffs _____ Tabs _____ Nebulizer	_____ _____ _____
_____	_____ Puffs _____ Tabs _____ Nebulizer	_____ _____ _____

CALL YOUR HEALTH CARE PROVIDER: _____

DANGER – Get Help! Take these medicines and call your provider now.

Your Asthma is <u>getting worse</u> fast:
- Medicine is not helping
- Breathing is hard and fast
- Nose opens wide
- Ribs show
- Can't talk well

OR

Peak flow Less than _____

MEDICINE	HOW MUCH	HOW OFTEN/WHEN
_____	_____ Puffs _____ Tabs _____ Nebulizer	_____ _____ _____
_____	_____ Puffs _____ Tabs _____ Nebulizer	_____ _____ _____

Get help from a provider now! Do not be afraid of causing a fuss. Your provider will want to see you right away. It's important! If you cannot contact your provider, go directly to the emergency room and bring this form with you. DO NOT WAIT.
Make an appointment with your primary care provider within two days of an ED visit or hospitalization.

If your student remains in the yellow red zone after 2 doses of rescue medication are administered per action plan parents will be notified to pickup the student for closer monitoring.

Self-Carry and Self Administration of Medication
This student will be allowed to carry the medications and supplies listed on this care plan on his/her person or to keep these medications and supplies in his/her locker or P.E. locker, as we consider him/her responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency of the use of these medications and supplies. If he/she feels the need to use the medications or supplies, he/she may use them and then report to the school nurse or office so that the use of these medications and supplies may be recorded and monitored. He/she will be required to demonstrate proper self-administration technique to the school nurse at the beginning of the year and as she deems necessary.

Physician Agreement? ☐ Yes ☐ No

This Asthma Medical Management Plan has been approved by:

_____ _____
Physician/Health Care Provider Signature Date

The Washington School District shall incur no liability as a result of any injury arising from the student's self-management and administration of the medications and procedures listed in this care plan, and the parents/guardians shall indemnify and hold harmless the district and its employees or agents against any claims arising out of the student's self-management and administration of medications and procedures. We, the undersigned, absolve the Washington School District of any responsibility in safeguarding our child's medication.

Exchange of Information
I give permission for qualified school staff to contact the physician(s) listed on this care plan and discuss my child's medical conditions and treatment as needed.

I give permission to the school nurse, trained asthma personnel, and other designated staff members of **SCHOOL DISTRICT OF WASHINGTON** to perform and carry out the asthma care tasks as outlined by _____'s Asthma Medical Management Plan. I also consent to the release of the information contained in this Asthma Medical Management Plan to all staff members, First Student Transportation Company, and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.
Acknowledged and received by:

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/Guardian Signature Date

Received in Nurses Office on:_____