Winfield R-IV School District
Asthma Action Plan
Emergency Care Plan

Place Student's Picture Here

TO BE COMPLETED BY PARENT

Student _____ **D.O.B.** _____ **Teacher/Grade** _____

Treating Healthcare Provider _____ **Phone** _____ **Fax** _____

Medication Taken At Home Daily _____

TO BE COMPLETED BY HEALTHCARE PROVIDER ONLY

Severity Classification	Triggers	Exercise
❍ Intermittent	❍ Colds ❍ Smoke ❍ Weather	1. Premedication (how much and when)
❍ Mild Persistent	❍ Exercise ❍ Dust ❍ Air Pollution	_____
❍ Moderate Persistent	❍ Animals ❍ Food	2. Exercise modifications _____
❍ Severe Persistent	❍ Other _____	_____

GREEN ZONE: Doing well **Peak Flow Meter** ☐ **YES** ☐ **NO** **If checked YES,**

Symptoms
- ✓ Breathing is good
- ✓ No cough or wheeze
- ✓ Can work and play

Use these controller medicines *every day* to keep you in the green zone:

Medicine: **How much to take:** **When to take it:**

_____ ☐ **HOME**

_____ ☐ **SCHOOL**

❍ 5-15 minutes before very active exercise, use _____

YELLOW ZONE: Getting Worse ***Contact physician if using quick relief more than 2 times per week***

Symptoms
- ✓ First sign of cold
- ✓ Exposure to known
- ✓ trigger
- ✓ Cough
- ✓ Mild wheeze
- ✓ Tight chest
- ✓ Coughing at night
- ✓ Other _____

Continue control medicines and add:

Medicine: **How much to take:** **When to take it:**

_____

_____

IF your symptoms (and peak flow, if used) ***DO NOT*** *return to* ***Green Zone*** *after _____ of the quick-relief treatment or if they progress to the* ***Red Zone****, THEN* _____

_____

RED ZONE: Getting Worse ***MEDICAL ALERT***

MEDICAL ALERT
- ✓ Very short of breath
- ✓ Difficulty talking
- ✓ Unable to walk
- ✓ Lips, skin or fingernails gray/blue
- ✓ Quick-relief medicines have not helped
- ✓ Cannot do usual activities
- ✓ Other _____

Continue control medicines and add:

Medicine: **How much to take:** **When to take it:**

_____

_____

Send by ambulance if:
- ❍ Still in the red zone after 15 minutes
- ❍ Other _____

IMMEDIATELY send by ambulance if:
- ❍ Trouble walking/talking due to shortness of breath
- ❍ Lips, skin or fingernails gray/blue
- ❍ Other _____

List Known Medical Conditions, Medications & Allergies: _____

_____	_____	_____	_____
Physician/Healthcare Provider (Print)	Physician/Healthcare Provider (Signature)	Date	Phone number

TURN FORM OVER

*****The Permission for Medication Administration Form must be completed in addition to the Asthma Action Plan if medication is required at school.*****

		
1. Shake the medicine	**2. Take a deep breath in and out fully and then press down on the inhaler to release a spray of medication into the mouth.**	**3. Hold your breath for at least 5-10 seconds, or as long as comfortable. Breathe out slowly**

Parent/Guardian Authorization and Permission for Release of Information

1. I give permission for the above information to be shared in confidence with appropriate staff and emergency personnel. In the event of an emergency, I authorize school personnel to obtain emergency medical care and/or emergency transportation by ambulance to the hospital.
2. I give permission for the school nurse to contact my child's health care provider to obtain any medical information pertaining to my child's allergy.
3. I request that the above medication(s) be sent on field trips.
4. I agree with the above Allergy Action Plan and give permission for the medication(s) to be given by school personnel as delegated, trained, and supervised by the school nurse.

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

EMERGENCY INFORMATION

Student Name: _____

Parent Name:_____

Address:_____

City: _____State: _____ Zip:_____

Home Phone: _____

Alt. Phone Number: _____

EMERGENCY CONTACTS

Name:_____

Phone:_____

Relationship: _____

Name:_____

Phone:_____

Relationship: _____

FOR SCHOOL PERSONNEL ONLY

- **Medication authorization complete** ☐ **YES** ☐ **NO For:**_____
- **Medication maintained in nurse office** ☐ **YES** ☐ **NO For:**_____
- **Medication self-carried** ☐ **YES** ☐ **NO For:**_____
- **Copies of Action Plan provided to:** **Teacher(s)** ☐ **YES** ☐ **NO** **Principal's Office** ☐ **YES** ☐ **NO**
  Athletic ☐ **YES** ☐ **NO** **Food Service** ☐ **YES** ☐ **NO**
- **Staff trained in medication administration** ☐ **YES** ☐ **NO**

_____ _____ _____
School Personnel (Print) School Personnel (Signature) Date

_____ _____ _____
School Personnel (Print) School Personnel (Signature) Date

_____ _____ _____
School Personnel (Print) School Personnel (Signature) Date

FULL ALLERGY PLAN HAS BEEN IMPLEMENTED

_____ _____ _____
Nurse Signature **Nurse Signature** **Date**