NEW MEXICO ASTHMA ACTION PLAN FOR SCHOOLS

Date_____

School District _____ School Name _____

School Nurse / Health Asst. _____ School Phone # / FAX # _____ /_____

PARENT/GUARDIAN: Please complete the information in the top sections and sign consent at bottom of the page.

Student Name	**Date of Birth**	**Student #**
***Health Care Provider Name/Title**	**Provider's Office Phone / FAX #**	
Parent/Guardian	**Parent's Phone #s**	
Emergency Contact	**Contact Phone #s**	
Allergies to Medications:		

Date of last medical exam: ___/___/_____	**Inhaler is kept:** ☐ with student ☐ Health Office ☐ Classroom ☐ Other: _____
Date of last Flu Shot: ___/___/_____	**Inhaler expires on:** ___/___/_____

Asthma Triggers Identified (Things that make your asthma worse):
☐ Exercise ☐ Colds ☐ Smoke (tobacco, fires, incense) ☐ Pollen ☐ Dust ☐ Strong Odors ☐ Mold/moisture ☐ Stress ☐ Pests (rodents, cockroaches)
☐ Gastroesophogeal reflux ☐ Season: Fall, Winter, Spring, Summer ☐ Animals ☐ Other (food allergies):_____

HEALTH CARE PROVIDER: Please complete Severity Level, Zone Information and Medical Order Below

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

Green Zone: Go - You're Doing Well! Take Control Medications EVERYDAY to Prevent Symptoms

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

Peak Flow may be useful for some students.

☐ ***No** controller medication is prescribed.*

☐ _____, _____ puff(s) MDI **with spacer** _____ times a day
Inhaled corticosteroid or inhaled corticosteroid/long-acting β-agonist

☐ _____, _____nebulizer treatment(s) _____ times a day
Inhaled corticosteroid

☐ _____, take _____ by mouth once daily at bedtime
Leukotriene antagonist — Always rinse mouth after using your daily inhaled medication.

For asthma with exercise, ADD:

☐ _____, _____ puff(s) MDI with spacer 5 to 15 minutes before exercise

Inhalers work better with spacers. Always use a mask when prescribed.

Yellow Zone: Slow Down! Continue Green Zone Medicine & ADD RESCUE Medicines-

You have ***ANY*** of these:
- **First signs of a cold**
- Cough or mild wheeze
- Exposure to known trigger
- Problems sleeping, playing, or working
- Cough at night

DO NOT LEAVE STUDENT ALONE! Call Parent/Guardian when rescue medication is given.

☐ _____, _____ puff(s) MDI **with spacer** & every_____ hours as needed
Fast-acting inhaled β-agonist

OR

☐ _____, _____ **nebulizer** treatment(s) & every_____ hours as needed
Fast-acting inhaled β-agonist

Red Zone: DANGER – Get Help! TAKE THESE MEDICINES NOW AND GET MEDICAL HELP NOW!

Your asthma is getting worse fast:
- Cannot talk, eat, or walk well
- Medicine is not helping or
- Getting worse, not better
- Breathing hard & fast
- Blue lips & fingernails

DO NOT LEAVE STUDENT ALONE! Call 911 and start treatment then call Parent/Guardian.

☐ _____, _____ puff(s) MDI **with spacer every_____ minutes** until EMS arrives
Fast-acting inhaled β-agonist

☐ **For schools with 02:** (Only use Oxygen if Pulse Oximeter available)
Give 02 to keep sat. above 92% unless otherwise contraindicated. Check sat. continually until EMS arrives.

√ *Make an appointment with your doctor within **two days** of an **emergency visit, hospitalization**, or anytime for **ANY** problem or question about asthma*
School Nurse: Call provider for control concerns or if rescue medication is used more than 2 times per week for asthma symptoms
Parents: Call your child's doctor for control concerns or if rescue medication is used more than 2 times per week for asthma symptoms

HEALTH CARE PROVIDER ORDER AND SCHOOL MEDICATION CONSENT

Check all that apply:

____ Student has been instructed in the proper use of his/her asthma medications and IS ABLE TO CARRY AND SELF-ADMINISTER his/her INHALER AT SCHOOL.

____ Student is to notify designated school health personnel after using inhaler at school.

____ Student needs supervision or assistance when using inhaler.

____ Student is unable to carry his/her inhaler while at school.

***SIGNATURE/TITLE**: _____ **DATE**: _____

Parent/Guardian:

I approve of this asthma action plan. I give my permission for the school nurse and trained school personnel to follow this plan, administer medication(s), and contact my provider, if necessary, and share this plan with the SBHC, if applicable. I assume full responsibility for providing the school with the prescribed medications and delivery of monitoring devices. I give my permission for the school to share the above information with school staff that need to know and permission for my child to participate in any asthma educational learning opportunities at school.

SIGNATURE: _____ **DATE:**_____

SCHOOL NURSE: _____ **DATE:** _____