Madison School District 321

Asthma Action Plan
Individualized Health Care Plan (IHC)

School Year:	Student Picture
School:	
Grade:	

STUDENT INFORMATION

Student:		DOB:
Parent:	Phone:	Email:
Parent:	Phone:	Email:
Physician:	Phone:	Fax:
District Nurse: Kim Ward, RN	Phone: 503-871-2834	Fax: 208-359-3370

History of anaphylaxis where epinephrine was used? ◯ Yes ◯ No
** If Yes (please complete Allergy & Anaphylaxis Action Plan)---allergy to: _____

SPECIAL CONSIDERATIONS

Special considerations and precautions (regarding school activities, field trips, sports, etc.):

Green Zone: Doing Great!

Student has ALL of these:
- *** Breathing is easy**
- *** No cough or wheeze**
- *** Able to work and play normally**
- *** Peak flow rate > _____**
- *** Other _____**

Controller (preventive) medications **taken at home:**
Medication:_____ Dose_____ When_____
Medication:_____ Dose_____ When_____
Asthma triggers:_____

Preventive Instructions (see medication instructions in Yellow Zone below):
◯ Administer _____ minutes ***before*** exercise or exposure to a known trigger
◯ Other: _____

Yellow Zone: Caution!

Student has ANY of these:
- *** Coughing or wheezing**
- *** Tightness in chest**
- *** Shortness of breath**
- *** Peak flow rate < _____**
- *** Other _____**

Allow student to return to class or normal activity if symptoms relieved after using meds.

Administer Quick-Relief Meds - Location: ◯ backpack ◯ office ◯ other_____

Medication_____ Dose_____
◯ Inhaler with spacer (if available)
◯ Nebulizer ◯ Other _____
Possible side effects: _____

Medication_____ Dose_____
◯ Inhaler with spacer (if available)
◯ Nebulizer ◯ Other _____
Possible side effects: _____

a separate Medication Request Form is required for each medication

Red Zone: EMERGENCY! Call 911!

Student has ANY of these:
- *** No improvement 10 minutes after receiving medications**
- *** Can't eat or talk well**
- *** Breathing hard and fast**
- *** Rib or neck muscles show when breathing in**
- *** Gasping for air**
- *** Lips and/or nail beds blue**
- *** Hunched over**

Call 911 and stay with the student
Repeat **Quick-Relief Medication** every 20 minutes until medical help arrives
(see medication instructions in Yellow Zone above)
Call Parent/Guardian/Emergency Contacts
Notify District Nurse
Document on Incident Report Form

If student becomes unconscious, have someone else call 911 and administer CPR!

PARENT TO COMPLETE

As Parent/Guardian of the named student:

* I give permission for my child's Health Care Provider to release/share information with the District Nurse for the completion of this plan of care and to exchange health information and records.
* I understand the information contained in this plan will be shared with school staff on a need-to-know basis.
* I give permission to the District Nurse and other designated staff to follow this Emergency Care Plan and administer medication as directed.
* I agree to release, indemnify, and hold harmless the District Nurse and other designated staff from lawsuits, claim expense, demand or action, etc., against them for helping my child with asthma treatment, provided the personnel are following physician instruction as written in the emergency action plan above.
* I understand I am responsible for maintaining necessary supplies, medication, and equipment.
* My child and I understand there are serious consequences for sharing any medication with others.
* I understand I am responsible to notify the District Nurse of any change in my child's health status, care, or medication order. If the prescription on the medication order is changed, I understand a new Medication Request Form and Emergency Care Plan Form must be completed before the school staff can administer the medication.
* I understand that if Emergency Medical Services (EMS) are called to evaluate/treat my child, he/she may not remain at school unless he/she is cleared in writing by a medical professional or unless I can be present to monitor him/her for symptoms. I understand that trained school employee volunteers can only monitor him/her until I arrive or EMS arrive.

Parent Name:	**Phone:**
Parent Signature:	**Date:**

PHYSICIAN TO COMPLETE

This student is under my care. This Asthma Action Plan reflects my plan of care.

◯ It is **medically appropriate** for this student to **self-carry and self-administer** asthma medication, when able and appropriate, and be in possession of asthma medication and supplies at all times. The medication(s) prescribed for this student is/are identified one page (1) of this Asthma Action Plan.

***** The student has been trained and has demonstrated proper administration procedure.***

◯ It is **medically appropriate** for the student to **self-carry** asthma medication and supplies at all times, but **NOT to self-administer** medication. Please have the designated school personnel administer this student's medication.

◯ It is **NOT medically appropriate** for the student to **self-carry or self-administer** this medication. Please have the designated school peronnel maintain this student's medication, testing suplies, and administer the student's medication.

Prescriber Name:	**Phone:**
Prescriber Signature:	**Date:**
District Nurse:	**Date:**