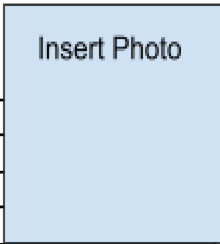
Hortonville Area School District

Health Services-Asthma action plan



Student Name:	Birth Date:
Parent/Guardian:	Work Phone:
Cell Phone:	Home Phone:
Provider:	Phone:
Grade:	Teacher:

Asthma Severity: Intermittent☐ Mild Persistent ☐ Severe Persistent☐ Many or severe asthma attacks/exacerbations☐
Asthma Triggers: (List)_______________________

☺ GREEN ZONE Have the child take these medications every day, even when child feels well.

Always use a spacer with inhalers as directed.
Exercise Pretreatment Medication: NA ☐ Albuterol ☐ Other _________Take _____ puffs 15min before activity as needed. ☐
Repeat every 4 hours as needed. Other ☐____
Controller Medication(s): ____
Controller Medication(s) Given in School: NA ☐____
Rescue Medication: Albuterol ☐ ____puffs every 4 hours as needed. Other ☐____________________________________

YELLOW ZONE Begin the sick treatment plan if the child has a cough, wheeze, shortness of breath, or tight chest. Have the child take these medications when sick.

Stop physical activity.
Rescue Medication: ☐ Albuterol ☐ Other_________ Take ____puffs every 4 hours as needed. Other ☐_______________
Call parent/guardian and school nurse.
If symptoms get worse, follow the red zone.

☹ RED ZONE If breathing is hard and fast, ribs sticking out, trouble walking, talking. GET HELP NOW.

Take rescue medicine(s) now
Rescue Medication: ☐ Albuterol ☐ Other_________ Take ____puffs every______ minutes for _______treatments as needed
Other ☐____
Call 911 and inform EMS for reason of call.
Call parent/guardian and school nurse.
Encourage student to take slow, deep breaths.
If symptoms continue, repeat quick relief med as above, or ☐ other

INSTRUCTIONS for QUICK RELIEF INHALER USE: CHECK APPROPRIATE BOX(ES)
☐ Both the provider and the parent/guardian feel that the student may carry and self-administer their inhaler.
☐ Student is to notify their designated school health official after using inhaler.
☐ Student needs supervision or assistance to use their inhaler and inhaler is to remain in health office.

______________________	______________________	______________	________
Health Care Provider (printed)	**Health Care Provider Signature**	**Phone/Fax**	**Date**

TO BE COMPLETED BY PARENT/GUARDIAN

Medication consent:I hereby give permission to designated trained school personnel to give medication to my child during the school day, including when away from school property on official school business, according to the written instructions of the practitioner as shown on this form. I also hereby agree to give my permission to the school nurse and/or school personnel to contact the child's physician if needed. I further agree to hold the Hortonville Area School District, and the HASD employee(s) who is (are) administering the medication harmless in any or all claims arising from the administration of this medication at school. I agree to notify the school at the termination of this request or when any change in the above orders is necessary. If self-medication is allowed, I ask that my child be permitted to self-medicate as authorized by my physician and myself. I understand, as the parent, I am responsible to assure that backup rescue medication is available to my child after school hours and traveling to/from and during school-sponsored events.

______________________	______________________	______________
Parent Name (Printed)	**Parent Signature**	**Date**

Copies of health plans are provided to teachers, school staff, lunch/recess aides, and bus driver(s)