



**School Nursing  
Asthma IHP**

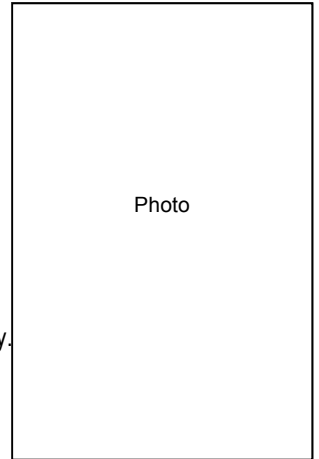
<input type="checkbox"/>	<b>Fennville Public Schools</b>
<input type="checkbox"/>	<b>Hamilton Public Schools</b>
<input type="checkbox"/>	<b>Holland Christian Schools</b>
<input type="checkbox"/>	<b>Holland Public Schools</b>
<input type="checkbox"/>	<b>West Ottawa Public Schools</b>

*Medications may be administered at school by school personnel when necessary for school attendance. This completed form, along with the medication and/or special equipment items are to be brought to the school by the parent/guardian.*

**TO BE COMPLETED BY PARENT / GUARDIAN**

I, the parent/guardian of \_\_\_\_\_ date of birth \_\_\_\_\_

request that the building administrator or his/her designee administer the medication or procedure listed below as directed. I give my consent for the exchange of information between the school and my child's health care provider. I give permission to share, if necessary, this information with school personnel who may be involved with the welfare of my child. I fully realize I can withdraw my request/consent in writing at any future date.



As a parent, I understand my responsibilities are:

1. To provide the school with a supply of medication in the original container appropriately labeled by the pharmacy.
2. To provide the school with the written doctor's instructions for medication administration during school hours And that medication will not be administered until signed doctors instructions are at school.
3. To inform the school of any medical changes.
4. To provide the school with this signed consent form annually and when changes in medication occur.
5. I give permission for my child to self administer rescue medication if approved by physician

**Please complete attached asthma action plan from American Lung Association, or submit a current plan already on file in physician office.**

Signature of Parent/Guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Physician's Name (printed): \_\_\_\_\_

Phone Number: \_\_\_\_\_ FAX Number: \_\_\_\_\_

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# Asthma Action Plan



## General Information:

Name \_\_\_\_\_  
 Emergency contact \_\_\_\_\_ Phone numbers \_\_\_\_\_  
 Physician/healthcare provider \_\_\_\_\_ Phone numbers \_\_\_\_\_  
 Physician signature \_\_\_\_\_ Date \_\_\_\_\_

Severity Classification	Triggers	Exercise
<input type="radio"/> Intermittent <input type="radio"/> Moderate Persistent <input type="radio"/> Mild Persistent <input type="radio"/> Severe Persistent	<input type="radio"/> Colds <input type="radio"/> Smoke <input type="radio"/> Weather <input type="radio"/> Exercise <input type="radio"/> Dust <input type="radio"/> Air Pollution <input type="radio"/> Animals <input type="radio"/> Food <input type="radio"/> Other _____	1. Premedication (how much and when) _____ 2. Exercise modifications _____

## Green Zone: Doing Well

### Symptoms

- Breathing is good
- No cough or wheeze
- Can work and play
- Sleeps well at night

### Peak Flow Meter

More than 80% of personal best or \_\_\_\_\_

## Peak Flow Meter Personal Best =

### Control Medications:

Medicine	How Much to Take	When to Take It
_____	_____	_____
_____	_____	_____
_____	_____	_____

## Yellow Zone: Getting Worse

### Symptoms

- Some problems breathing
- Cough, wheeze, or chest tight
- Problems working or playing
- Wake at night

### Peak Flow Meter

Between 50% and 80% of personal best or \_\_\_\_\_ to \_\_\_\_\_

## Contact physician if using quick relief more than 2 times per week.

### Continue control medicines and add:

Medicine	How Much to Take	When to Take It
_____	_____	_____
_____	_____	_____
_____	_____	_____

**IF your symptoms (and peak flow, if used) return to Green Zone after one hour of the quick-relief treatment, THEN**

- Take quick-relief medication every 4 hours for 1 to 2 days.
- Change your long-term control medicine by \_\_\_\_\_
- Contact your physician for follow-up care.

**IF your symptoms (and peak flow, if used) DO NOT return to Green Zone after one hour of the quick-relief treatment, THEN**

- Take quick-relief treatment again.
- Change your long-term control medicine by \_\_\_\_\_
- Call your physician/Healthcare provider within \_\_\_\_\_ hour(s) of modifying your medication routine.

## Red Zone: Medical Alert

### Symptoms

- Lots of problems breathing
- Cannot work or play
- Getting worse instead of better
- Medicine is not helping

### Peak Flow Meter

Less than 50% of personal best or \_\_\_\_\_ to \_\_\_\_\_

## Ambulance/Emergency Phone Number:

### Continue control medicines and add:

Medicine	How Much to Take	When to Take It
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Go to the hospital or call for an ambulance if:**

- Still in the red zone after 15 minutes.
- You have not been able to reach your physician/healthcare provider for help.
- \_\_\_\_\_

**Call an ambulance immediately if the following danger signs are present:**

- Trouble walking/talking due to shortness of breath.
- Lips or fingernails are blue.