Allergy & Asthma Network
Mothers of Asthmatics

800.878.4403
www.aanma.org

ASTHMA ACTION PLAN

Date: ____________________

Name: ____________________

Doctor: ____________________

Doctor's Phone Number: ____________________

Hospital/Emergency Department Phone Number: ____________________

GREEN ZONE

Doing Well

- No cough, wheeze, chest tightness, or shortness of breath during the day or night
- Can do usual activities

Target Peak Expiratory Flow Rate (PEFR) should be between

__________ and __________

If prescribed, use a daily inhaled corticosteroid or other medication to prevent airway inflammation:

Medication ____________________

How much to take ____________________

When to take it ____________________

At first sign of symptoms or 5-15 minutes before exercise: ❐ Take: ____________________ ❐ 2 or ❐ 4 puffs

YELLOW ZONE

Symptoms Present

- Cough, wheeze, chest tightness, or shortness of breath, or
- Waking at night due to asthma, or
- Can do some, but not all, usual activities

-Or-

PEFR: __________ to __________

1 FIRST

Use albuterol or levalbuterol—and keep taking your GREEN ZONE medication.

____________________ ❐ 2 or ❐ 4 puffs, every 20 minutes for up to 1 hour

2 Second

If your symptoms or PEFR return to GREEN ZONE after 1 hour:

❐ Continue monitoring to be sure you stay in the green zone.

-Or-

If your symptoms or PEFR do not return to GREEN ZONE after 1 hour:

❐ Take: ____________________ ❐ 2 or ❐ 4 puffs or ❐ nebulizer

❐ Add: ____________________ mg per day for __________ (3–10) days
(oral corticosteroid)

❐ Call the doctor ❐ before/ ❐ within __________ hours after taking the oral steroid.

RED ZONE

Medical Alert!

- Very short of breath, or
- YELLOW ZONE medications have not helped, or
- Trouble walking and talking
- Lips or fingernails turn blue or discolored due to lack of oxygen
- Symptoms are same or get worse

-Or-

PEFR: less than __________

Take this medication:

❐ ____________________ ❐ 2 or ❐ 6 puffs or ❐ nebulizer

❐ ____________________ mg
(oral corticosteroid)

Call your doctor NOW. Go to the hospital or call an ambulance if:

❐ You are still in the red zone after 15 minutes AND

❐ You have not reached your doctor.

Exercise

- Prevent or reduce allergic reactions through allergen avoidance, medication or immunotherapy.
- Pre-medicate before exercise.
- Warm up and cool down 10 minutes pre and post exercise.
- Tailor exercise intensity until symptom-free.

- No physical activity until in yellow or green zone.

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Adapted from NIH Asthma Guidelines Asthma Action Plan

ARCHDIOCESE OF ATLANTA

MEDICATION PERMIT FORM

All medication should be given outside of school hours if possible. Three-times-a-day medications should be given before school, after school and at bedtime for optimal coverage. If necessary, medication can be given at school only under the following conditions:

1. If medication is needed in order for the student to remain in school, this form must be completed by the parent/guardian, signed by the physician, and returned with the medication to the school office or nurse.

2. All necessary medication prescribed for a student by a doctor or dentist must have this Medication Permit Form signed by the physician and parent. All prescription medication must be in the prescription bottle and labeled with a current pharmacy prescription label. "Over the counter" medication must be in original labeled container. Medications sent in baggies or unlabeled containers will not be given.

3. The **parent** is responsible to bring all medication to the clinic/office and to pick up unused medicine or it will be destroyed.

4. Experimental medication/dosages will not be given. Herbal medication, dietary supplements and other nutritional aids not approved as medication by the FDA, will not be administered at school.

5. Antibiotics will not be given at school by school personnel. If the parent feels the antibiotic must be given during the school day, the parent may come to the school office/clinic and administer it.

6. All medications must be kept in a locked cabinet/drawer in the school office/clinic and administered in the school office/clinic.

7. **High School** students whose doctor's written instructions require them to carry an inhaler on their person may do so. A second inhaler must also be kept in the clinic for use as needed. If a student allows another person to use the inhaler, the privilege of carrying one's inhaler may be revoked for both parties involved. Only those students in High School may transport their medication from home to the school office/clinic, and return unused medication home.

8. Only the **parent or adult designee** perform nebulizer treatments in school.

TO THE NURSE OR HEALTH REPRESENTATIVE OF: **ST. PIUS X CATHOLIC HIGH SCHOOL** ____________

NAME OF STUDENT: ______________________________ GRADE: _____ ROOM: _____

NAME OF MEDICATION: ______________________________

DOSAGE AND DIRECTIONS FOR GIVING: ______________________________

BEGINNING DATE: ______________________ ENDING DATE: ______________________

I hereby request that the medication specified above be given to the above named student, and that the medication may be given by someone other than a medically trained person.

I realize that the school does not have to agree to allow medication to be given to a student by school personnel. I understand that the school's agreeing to allow the medication to be given is for my benefit and the student's benefit. Such agreement by the school is adequate consideration of my agreements contained herein. In consideration for the school agreeing to allow the medication to be given to the student as requested herein, I agree to indemnify and hold harmless the Archdiocese of Atlanta, its servants, agents, and employees, including, but not limited to the parish, the school, the principal, and the individuals giving the medication, of and from any and all claims, demands, or causes of action arising out of or in any way connected with the giving of the medication or failing to give the medication to the student. Further, for said consideration, I, on behalf of myself and the other parent of the student, hereby release and waive any and all claims, demands, or causes of action against the Archdiocese of Atlanta, its agents, servants, or employees, including, but not limited to the parish (if applicable), the school, the principal, and the individual giving or failing to give the medication.

SIGNATURE OF PARENT/GUARDIAN: ______________________________ DATE: ____________

SIGNATURE OF PHYSICIAN: ______________________________ DATE: ____________
(STAMPED SIGNATURE NOT ACCEPTED)

PHYSICIAN'S TELEPHONE NUMBER: ______________________________

MEDICAL AGREEMENT WITH ______________________ CATHOLIC SCHOOL FOR STUDENT TO CARRY AND SELF-MEDICATE PRESCRIBED MEDICATION

I, ______________________________, as the parent of ______________________________,
Parent/Legal Guardian *Student Legal Name*

who is a student at ________________________ Catholic School, will follow the guidelines set forth below, in order for the student to carry his/her own medication on campus.

- I will submit a letter from the physician in which he/she states that the above named child is capable and knowledgeable of self-medicating procedures. The letter further states that it is a medical necessity for the above named student to carry his/her medication on campus.
- I will submit the Archdiocese of Atlanta Medication Permit Form, signed by me and my child's physician.
- I will be responsible to supply the nurse with a duplicate medication to be kept in the clinic.
- My child and I will meet with the Administration and the school nurse to have my child demonstrate his/her competence in self-administration of his/her medication. If the school nurse believes the student is too young or does not show sufficient understanding of how and when to self-medicate, the student will not be allowed to carry the medication on campus.
- I will educate my child to report immediately to the clinic after self-administration. The school nurse will activate emergency medical procedures by calling 911 and will log the incident.
- I will educate my child to the fact that no other student should ever have possession of his/her medication/medication bag.
- I will educate my child that the abuse of this medication on campus will preclude the child from further being able to carry said medication on campus.
- The school will revoke the permission for said child to carry his/her medication due to any misuse of the prescription medication on campus.

The medication to be carried is ____, and it will

be carried in ____.

I, ______________________________, as parent/guardian of ______________________________,
Parent/Legal Guardian *Student Legal Name*

take full responsibility for the actions of my child as a result of carrying this medication and assume all liability regarding said child and the carrying of his/her prescription medication on campus.

______________________________	________	______________________________	________
Parent/Legal Guardian	*Date*	*Student Signature*	*Date*
______________________________	________	______________________________	________
School Administrator	*Date*	*Nurse*	*Date*