

NEW MEXICO ASTHMA ACTION PLAN FOR SCHOOLS

Date _____

School District _____

School Name _____

School Nurse / Health Asst. _____

School Phone # / FAX # _____ / _____

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



GREEN means Go!
Use **CONTROL** medicine daily

YELLOW means Caution!
Add **Rescue** medicine

RED means **EMERGENCY!**
Get help from a provider **now!**

Asthma Severity: <input type="checkbox"/> Intermittent or Persistent: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	Asthma Triggers Identified (Things that make your asthma worse): <input type="checkbox"/> Exercise <input type="checkbox"/> Colds <input type="checkbox"/> Smoke (tobacco, fires, incense) <input type="checkbox"/> Pollen <input type="checkbox"/> Dust <input type="checkbox"/> Animals _____ <input type="checkbox"/> Strong Odors <input type="checkbox"/> Mold/moisture <input type="checkbox"/> Stress/Emotions <input type="checkbox"/> Pests (rodents, cockroaches) <input type="checkbox"/> Gastroesophageal reflux <input type="checkbox"/> Season: Fall, Winter, Spring, Summer <input type="checkbox"/> Other: _____	Date of Last Flu Shot: ____/____/____	Inhaler is kept: <input type="checkbox"/> With Student <input type="checkbox"/> In Classroom <input type="checkbox"/> In Health Office <input type="checkbox"/> Other _____
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Health care provider: Please complete the following information for all zones:

Green Zone: Go! Take Control Medications EVERY DAY

You have ALL of these: <ul style="list-style-type: none"> Breathing is easy No cough or wheeze Can work and play No symptoms at night Peak flow (optional): Greater than \geq _____ (More than 80% of Personal Best)	<input type="checkbox"/> No control medicine required. Always rinse mouth after using your daily inhaled medicine. <input type="checkbox"/> _____ puff(s) MDI with spacer _____ times a day <small>Inhaled corticosteroid or inhaled corticosteroid/long-acting β-agonist</small> <input type="checkbox"/> _____ nebulizer treatment(s) _____ times a day <small>Inhaled corticosteroid</small> <input type="checkbox"/> _____, take _____ by mouth once daily at bedtime <small>Leukotriene antagonist</small> For asthma with exercise, ADD: <input type="checkbox"/> _____ puff(s) MDI with spacer 15 minutes before exercise For nasal/environmental allergy, ADD: <input type="checkbox"/> _____
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Yellow Zone: Caution! Continue CONTROL Medicine & ADD RESCUE Medicines-

You have ANY of these: <ul style="list-style-type: none"> Cough or mild wheeze Tight chest First signs of a cold Problems sleeping, Playing or working Peak flow (optional): _____ to _____ (50%- 80% of Personal Best)	DO NOT LEAVE STUDENT ALONE! Call Parent/Guardian when rescue med is administered. <input type="checkbox"/> _____ puff(s) MDI with spacer & every _____ hours as needed <small>Fast-acting inhaled β-agonist</small> OR <input type="checkbox"/> _____ nebulizer treatment(s) & every _____ hours as needed <small>Fast-acting inhaled β-agonist</small> <input type="checkbox"/> Other _____ Call your MEDICAL PROVIDER if you have these signs more than two times a week, or if your rescue medicine does not work! If symptoms are NOT better OR peak flow is NOT improved, go to RED ZONE.
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Red Zone: EMERGENCY! Continue CONTROL Medicine & ADD RESCUE Medicines and GET HELP!

You have ANY of these: <ul style="list-style-type: none"> Cannot talk, eat, or walk well Medicine is not helping or Getting worse, not better Breathing hard & fast Blue lips & fingernails Peak flow (optional): Less than \leq _____ (Less than 50% of Personal Best)	DO NOT LEAVE STUDENT ALONE! → Call for emergency 911 and start treatment <input type="checkbox"/> _____ puff(s) MDI with spacer & every 20 minutes until paramedics arrive <small>Fast-acting inhaled β-agonist</small> OR <input type="checkbox"/> _____ nebulizer treatment(s) every 20 minutes until paramedics arrive <small>Fast-acting inhaled β-agonist</small> <input type="checkbox"/> Other _____ Call 911 immediately and call Parent/Guardian
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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 should not 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. I assume full responsibility for providing the school with the prescribed medications and delivery and 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: _____

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