Dear Parents and Guardians,

According to our health records, your child has a history of asthma. Would you and your child's health care provider please fill out and sign the attached **"Asthma Action Plan"** form and return it to school so that we can provide accurate information to appropriate school personnel and ensure appropriate care to your child.

If you would like your child to **independently carry and use an inhaler** during school hours and for school activities, the **"Authorization for Student Possession and Use of an Asthma Inhaler"** form needs to be completed by the health care provider and signed by yourself.

Please call or e-mail your school's nurse or health aide if you have any questions or concerns.

Sincerely,
Westerville City Schools Nurses

# Asthma Action Plan for Home and School

AMERICAN LUNG ASSOCIATION®

Name _____ DOB ____/____/_____

**Severity Classification** ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

**Asthma Triggers** (list) _____

**Peak Flow Meter Personal Best** ____

## 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)

| Control Medicine(s) | Medicine | How much to take | When and how often to take it | Take at |
|---|---|---|---|---|
| | _____ | _____ | _____ | ☐ Home ☐ School |
| | _____ | _____ | _____ | ☐ Home ☐ School |

**Physical Activity** ☐ Use albuterol/levalbuterol ____ puffs, 15 minutes before activity ☐ with all activity ☐ when the child feels he/she needs it

## Yellow Zone: Caution

**Symptoms: Some problems breathing – Cough, wheeze, or chest tight – Problems working or playing – Wake at night**
**Peak Flow Meter** _____ to _____ (between 50% and 79% of personal best)

**Quick-relief Medicine(s)** ☐ Albuterol/levalbuterol ____ puffs, every 4 hours as needed

**Control Medicine(s)** ☐ Continue Green Zone medicines

☐ Add _____ ☐ Change to _____

**The child should feel better within 20–60 minutes of the quick-relief treatment. If the child is getting worse or is in the Yellow Zone for more than 24 hours, THEN follow the instructions in the RED ZONE and call the doctor right away!**

## Red Zone: Get Help Now!

**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)

**Take Quick-relief Medicine NOW!** ☐ Albuterol/levalbuterol ____ puffs, _____ (how frequently)

**Call 911 immediately if the following danger signs are present**
- Trouble walking/talking due to shortness of breath
- Lips or fingernails are blue
- Still in the red zone after 15 minutes

**School Staff:** Follow the Yellow and Red Zone instructions for the quick-relief medicines according to asthma symptoms.
The only control medicines to be administered in the school are those listed in the Green Zone with a check mark next to "Take at School".

☐ **Both the Healthcare Provider and the Parent/Guardian** feel that the child has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

### Healthcare Provider

Name _____ Date _____ Phone (_____) _____-_____ Signature _____

### Parent/Guardian

☐ I give permission for the medicines listed in the action plan to be administered in school by the nurse or other school staff as appropriate.
☐ I consent to communication between the prescribing health care provider or clinic, the school nurse, the school medical advisor and school-based health clinic providers necessary for asthma management and administration of this medicine.

Name _____ Date _____ Phone (_____) _____-_____ Signature _____

### School Nurse

☐ The student has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

Name _____ Date _____ Phone (_____) _____-_____ Signature _____



**Please send a signed copy back to the provider listed above.**

**Ohio Department of Health**

# Authorization for Student Possession and Use of an Asthma Inhaler

In accordance with ORC 3313.716/3313.14

**A completed form must be provided to the school principal and/or nurse before the student may possess and use an asthma inhaler in school to alleviate asthmatic symptoms, or before exercise to prevent the onset of asthmatic symptoms.**

| Student name |
|---|
| Student address |

**This section must be completed and signed by the student's parent or guardian.**

*As the Parent/Guardian of this student, I authorize my child to possess and use an asthma inhaler, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant.*

| **Parent /Guardian signature** | Date |
|---|---|
| Parent/Guardian name | Parent/Guardian emergency telephone number ( ) |

**This section must be completed and signed by the student's physician.**

| Name and dosage of medication | |
|---|---|
| Date medication administration begins | Date medication administration ends (if known) |

| Procedures for school employees if the medication does not produce the expected relief |
|---|

Possible severe adverse reactions:

| To the student for which it is prescribed (that should be reported to the physician) |
|---|
| To a student for which it is ***not*** prescribed who receives a dose |

| Special instructions |
|---|

| **Physician signature** | Date |
|---|---|
| Physician name | Physician emergency telephone number ( ) |

Adapted from the Ohio Association of School Nurses