CAMDEN COUNTY SCHOOLS

311 South East Street
Kingsland, GA 31548

Telephone: (912) 729-5687

Dr. Tracolya Green, Superintendent

Student Asthma Action Plan for _____

Physician Name:_____ **Physician Phone:**_____

Emergency Plan

Emergency action is necessary when the student has symptoms such as:

- ☐ Tightness in chest
- ☐ Increase in Breathing Rate
- Peak flow reading of _____
- ☐ Excessive/increased Cough
- ☐ Wheezing
- ☐ Chest/Neck pull in with breathing

Step 1: If student has any of the above listed symptoms, ***give medications as listed below*** and check peak flow. Follow instructions below.

GREEN ZONE Good Response	YELLOW ZONE Fair Response	RED ZONE Poor Response
*Breathing rate normal *Skin color pink *Alert and active *No chest tightness *No cough	*Breathing rate normal or increasing *Mild difficulty breathing *Skin color pink *Mild cough *Mild chest tightness *Peak flow _____to _____	*Breathing rate fast *Severe Breathlessness *Skin pulling between ribs with each breath *Nasal flaring *Continual cough *Peak flow _____to _____
⇩	⇩	⇩
Return to Normal Routine	Call Parent and continue to observe.	Get Emergency Treatment!

Emergency Asthma Medications:

	Name	Amount	When to Use
1.			
2.			

Daily Asthma Management Plan

Identify the things which start an asthma episode (Check each that applies to student.)

- ☐ Exercise
- ☐ Respiratory infections
- ☐ Change in temperature
- ☐ Food_____
- ☐ Strong odors or fumes
- ☐ Chalk dust/ dust
- ☐ Carpets in the room
- ☐ Other_____
- ☐ Animals
- ☐ Pollens
- ☐ Molds

Comments:_____

⇨ ***See reverse for more instructions ** ⇦

Control of School Environment

(List any pre-medications, and/or dietary restrictions that the student needs to prevent an asthma episode.)

_____

_____

_____

Peak Flow Monitoring

Personal best peak flow number:_____Monitoring times:_____

Daily Medication Plan

	Name	Amount	When to use
1.			
2.			
3.			
4.			

Comments/Special Instructions

_____

Parent/Guardian Signature* _____ ***Date*_____

*** Physician Signature or Stamp** _____ Date:_____

****PHYSICIAN TO COMPLETE INFORMATION BELOW *IF* STUDENT IS ALLOWED TO CARRY INHALER. ****

___ I have instructed this student in the proper way to use his/her inhaler. It is my professional opinion that he/she should be allowed to carry and use the inhaler by him/herself. It is preferable that a second prescription labeled inhaler be kept in the clinic in case the first is lost or left at home.

_____

Physician Signature or Stamp Date

___ It is my professional opinion that this student should keep an inhaler in the school clinic for use as prescribed.

_____

Physician Signature or Stamp Date

___ I have been instructed in the proper use of my prescription labeled medication and fully understand how to administer this medication. I will not allow another student to use my medication under any circumstances. I also understand that should another student use my prescription, the privilege of carrying my medication may be revoked. I also accept the responsibility for checking in with the school nurse to keep her informed of use of my medication in case I start having problems.

_____

Student Signature Date

___ I hereby request that the above named student, over whom I have legal control, be allowed to carry and use the prescription medication described above, at school. I accept legal responsibility should the above medication be lost, given or taken by a person other than the above named student. I understand that if this should happen, the privilege of carrying the medication may be revoked. I release the Camden County School district and its employees of any legal responsibility when the above named student administers his/her own medication.

Parent/Guardian Signature Date