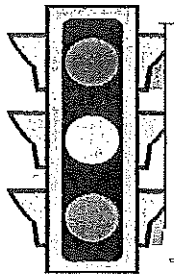
NEW MEXICO ASTHMA ACTION PLAN FOR SCHOOLS

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:	Asthma Triggers Identified (Things that make your asthma worse):	Date of Last Flu Shot:	Inhaler is kept:
☐ Intermittent *or* Persistent: ☐ Mild ☐ Moderate ☐ Severe	☐ Exercise ☐ Colds ☐ Smoke (tobacco, fires, incense) ☐ Pollen ☐ Dust ☐ Animals_____ ☐ Strong Odors ☐ Mold/moisture ☐ Stress/Emotions ☐ Pests (rodents, cockroaches) ☐ Gastroesophogeal reflux ☐ Season: Fall, Winter, Spring, Summer ☐ Other: _____	___/___/___	☐ With Student ☐ In Classroom ☐ In Health Office ☐Other_____

Health care provider: Please complete the following information for all zones:

Green Zone: Go! Take Control Medications EVERY DAY

You have **ALL** of these:
- Breathing is easy
- No cough or wheeze
- Can work and play
- No symptoms at night

Peak flow (optional):
Greater than ≥ _____
(More than 80% of Personal Best)

Personal best peak flow: _____

☐ No control medicine required.

Always rinse mouth after using your daily inhaled medicine.

☐ _____, _____ puff(s) MDI **with spacer** _____ times a day
Inhaled corticosteroid or inhaled corticosteroid/long-acting β-agonist

☐ _____, _____ nebulizer treatment(s) _____ times a day
Inhaled corticosteroid

☐ _____, take _____ by mouth once daily at bedtime
Leukotriene antagonist

For asthma with exercise, ADD:
☐ _____, _____ puff(s) MDI with spacer 15 minutes before exercise

For nasal/environmental allergy, ADD:
☐ _____

Yellow Zone: Caution! Continue CONTROL Medicine & ADD RESCUE Medicines-

You have **ANY** of these:
- 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.

☐ _____, _____ puff(s) MDI **with spacer** & every_____ hours as needed
Fast-acting inhaled β-agonist

OR

☐ _____, _____ **nebulizer** treatment(s) & every_____ hours as needed
Fast-acting inhaled β-agonist

☐ 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.

Red Zone: EMERGENCY! Continue CONTROL Medicine & ADD RESCUE Medicines and GET HELP!

You have ANY of these:
- 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 ≤ _____
(Less than 50% of Personal Best)

DO NOT LEAVE STUDENT ALONE! → Call for emergency 911 and start treatment

☐ _____, _____ puff(s) MDI **with spacer** & **every 20 minutes** until paramedics arrive
Fast-acting inhaled β-agonist

OR

☐ _____, _____ nebulizer treatment(s) every 20 minutes until paramedics arrive
Fast-acting inhaled β-agonist

Call 911 immediately and call Parent/Guardian

☐ Other _____

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:** _____