WAUWATOSA SCHOOL DISTRICT
Your Educational Community

Asthma Action Plan

PLAN MUST BE COMPLETED AT THE START OF EACH SCHOOL YEAR

Student Name_____ Date of Birth _____

- **Written consent from the parent/guardian AND student's practitioner must be received before any medication is administered.**
- It is the responsibility of the parent/guardian to provide the Office with any changes to medication administration orders and **for tracking and providing prescription medication to the Office as needed.**
- Staff may only administer medication as directed by the student's practitioner as is reflected on this form.
- The medication must not be expired, and in the original medication container with label from the pharmacy. (Ask the pharmacy to put a label on the inhaler, not the box)

Student's Inhaler will be kept in: •Office •Backpack (where: _____) •Other _____

HEALTH CARE PROVIDER, please complete all items in box:

Usual Asthma Symptoms (circle)**: •Cough •Shortness of Breath •Chest Tightness •Wheeze •Other_____**

Asthma Triggers: _____

Green Zone (doing well)

Symptoms: No Cough, wheeze or shortness of breath. Able to do all normal activities including exercise and play

Maintenance Medication needed at school: ☐ None ☐ see below

Name of Medication	how much/mgs	when and how often

Yellow Zone (getting worse)

Symptoms: Coughing, wheezing, shortness of breath, or chest tightness. Can do some but not all of usual activities

Quick Relief Medication:

Name of Medication	how much/mgs	when and how often

CALL PARENTS AND SCHOOL NURSE IF NOT BETTER AFTER 20 MINUTES

Red Zone (medical alert!)

Symptoms: Getting worse not better. Breathing hard and fast. Difficulty walking or talking. Hunched over to breathe.

Give this NOW:

Name of Medication	how much/mgs	when and how often

CALL PARENTS AND SCHOOL NURSE. IF PARENTS ARE NOT IMMEDIATELY REACHED, CALL 911.

Health Care Provider Signature _____ Date _____

Health Care Provider Name Printed_____ Phone _____

I give consent for school personnel to administer the above listed medication/s. I agree to notify the school in writing at the termination of this request or when any changes in the above order is necessary. I understand that all unused medication will not be returned to my student unless authorized to self-carry. Parents must come to the Office for unused medication by the last day of school or it will be disposed of. I authorize communication between the prescribing health care provider, the school nurse, and trained school personnel necessary for the management and administration of this medication.

Parent/Guardian Signature _____Date _____