

COVENANT CHRISTIAN ACADEMY
ASTHMA ACTION PLAN / PHYSICIAN'S ORDER



STUDENT'S NAME _____ DOB _____ GRADE _____

IDENTIFY KNOWN ASTHMA TRIGGERS (Check each that applies to this student)

Asthma Triggers (Things that make your asthma worse)

<input type="checkbox"/> Colds	<input type="checkbox"/> Dust	<input type="checkbox"/> Animals: _____	<input type="checkbox"/> Strong odors	Season
<input type="checkbox"/> Smoke (tobacco, incense)	<input type="checkbox"/> Acid reflux	<input type="checkbox"/> Pests (rodents, cockroaches)	<input type="checkbox"/> Mold/moisture	<input type="checkbox"/> Fall <input type="checkbox"/> Spring
<input type="checkbox"/> Pollen	<input type="checkbox"/> Exercise	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Stress/Emotions	<input type="checkbox"/> Winter <input type="checkbox"/> Summer

▼ Medical provider complete from here down ▼

Asthma Severity: Intermittent or Persistent: Mild Moderate Severe

Green Zone: Go!

You have **ALL** of these:

- Breathing is easy
- No cough or wheeze
- Can work and play
- Can sleep all night



Peak flow: _____ to _____
 (More than 80% of Personal Best)
Personal best peak flow: _____

Take these CONTROL (PREVENTION) Medicines EVERY Day

Always rinse your mouth after using your Inhaler and remember to use a spacer with your MDI.

No control medicines required.
 Aerospire _____ Advair _____ Alvesco _____ Asmanex _____ Budesonide _____
 Dulera _____ Flovent _____ Pulmicort _____ QVAR _____ Symbicort _____
 Other: _____
 _____ puff (s) MDI _____ times a day **Or** _____ nebulizer treatment(s) _____ times a day
 (Montelukast) Singulair, take _____ by mouth once daily at bedtime

For asthma with exercise, ADD: Albuterol Xopenex Ipratropium, MDI, 2 puffs with spacer 15 minutes before exercise (i.e., PE class, recess, sports)

Yellow Zone: Caution!

You have **ANY** of these:

- Cough or mild wheeze
- First sign of cold
- Tight chest
- Problems sleeping, working, or playing



Peak flow: _____ to _____
 (60% - 80% of Personal Best)

Continue CONTROL Medicines and ADD RESCUE Medicines

Albuterol Levalbuterol (Xopenex) Ipratropium (Atrovent), MDI, _____ puffs with spacer every _____ hours as needed
 Albuterol 2.5 mg/3ml Levalbuterol (Xopenex) _____ Ipratropium (Atrovent) 2.5mg/3ml
 one nebulizer treatment every _____ hours as needed
 Other: _____

Call your Healthcare Provider if you need rescue medicine for more than 24 hours or two times a week, or if your rescue medicine doesn't work.

Red Zone: DANGER!

You have **ANY** of these:

- Can't talk, eat, or walk well
- Medicine is not helping
- Breathing hard and fast
- Blue lips and fingernails
- Tired or lethargic
- Ribs show



Peak flow: < _____
 (Less than 60% of Personal Best)

Continue CONTROL & RESCUE Medicines and GET HELP!

Albuterol Levalbuterol (Xopenex) Ipratropium (Atrovent), MDI, _____ puffs with spacer **every 15 minutes**, for **THREE** treatments.
 Albuterol 2.5 mg/3ml Levalbuterol (Xopenex) _____ Ipratropium (Atrovent) 2.5mg/3ml
 one nebulizer treatment **every 15 minutes**, for **THREE** treatments
 Other: _____

SEEK EMERGENCY MEDICAL CARE (911) IF

- No improvement 15-20 minutes after initial treatment.
- Breathing is hard and fast with difficulty walking, talking, or eating.
- Lips or fingernails are gray and blue accompanied by fatigue, weakness.
- Difficulty breathing with chest and neck pulled in.
- Audible wheezing may have subsided.

Confirm route of medications noted above (name/dosage of medication and route):

Green Zone Medications: _____

Yellow Zone Medications: _____

Red Zone Medications: _____

INTERVAL FOR REPEATING DOSAGE:

- If symptoms not relieved after initial dose: _____
- If symptoms reoccur before the next dose is due: _____

Possible and/or additional side effects of prescribed medications: _____

Additional Instructions: _____

SHOULD STUDENT CARRY HIS/HER ASTHMA MEDICATION? YES NO (circle one)

Healthcare Provider's Signature: _____ Date: _____

Healthcare Provider's Printed Name/Stamp _____

Phone #: _____

TO BE COMPLETED BY PARENT / GUARDIAN

Parent/Guardian Name: _____ Phone: _____

Parent/Guardian Name: _____ Phone: _____

My signature gives permission for the principal's designee to follow this plan, administer prescribed medication, and contact the healthcare provider if necessary. I also agree to pick up any unused medication at the end of the school year. I understand that medication not picked up by a parent/guardian at the end of the school year will be discarded.

Parent/Guardian Signature: _____ Date: _____

TO BE COMPLETED WITH CCA HEALTH OFFICE STAFF

Medication received by: _____ Date: _____

CCA Clinic Staff Signature

Medication picked up: _____ Date: _____

Parent / Guardian Signature

COVENANT CHRISTIAN ACADEMY

PARENT / STUDENT AGREEMENT FOR PERMISSION TO CARRY AN INHALER



Parent:

- I give my consent for my child to carry and self-administer his/her inhaler.
- I understand that the school board or its employees cannot be held responsible for negative outcomes resulting from self-administration of the inhaled asthma medication.
- This permission to possess and self-administer asthma medication may be revoked by the principal or CCA Clinic staff if it is determined that my child is not safely and effectively self-administering the medication.
- A new Asthma Action Plan signed by the physician and Parent/Student Agreement for Permission to Carry an Inhaler must be submitted each school year.

Parent/Guardian's Signature Required

Date

Student:

- I have demonstrated the correct use of the inhaler to the school's Clinic staff.
- I agree never to share my inhaler with another person or use it in an unsafe manner.
- I agree that I will notify a member of the school clinic staff (or another appropriate adult if the school clinic staff are not available or present) if I have self-administered my medication via inhaler.

Student's Signature Required

Date