Berrien Springs Public Schools
ASTHMA PLAN OF ACTION

Student Name:		
Regular HCP ☐ 504 HCP ☐	Date:	
School:	Grade:	
Student ID Number:	Birth Date:	
What Triggers Asthma Problems:		
		Picture of student

GREEN - MAINTENANCE (Usually administered at home) - Breathing is good - No coughing or wheezing - Can work & play **Peak Flow Number** **_____ to_____**	**Medication & Dose:** **When to give:**
YELLOW – CAUTION (Rescue Inhaler) - Coughing - Wheezing - Tight chest **Peak Flow Number** **_____ to _____**	**Medication & Dose:** **When to give:**
RED - DANGER (Example: Extra doses of rescue inhaler or nebulizer treatment) - Previous medicine dose is not helping - Breathing is hard & fast - Nose opens wide - Can't talk well or walk **Peak Flow Number** **_____to _____**	**Medication & Dose:** **When to give:** **DON'T HESITATE TO CALL 911**

Health Action Plan:

- Assess lung sounds and O2Sat
- Administer medication as ordered; verify 10 rights of medication administration before giving medication
- Continue assessing LS and O2Sat after treatment
- Do not hesitate in calling 9-1-1 if symptoms do not subside after treatment

Other health concerns related to Asthma:

Students 12 years of age or older may carry their own inhaler, please communicate with the main office for more details.

Inhaler Use Demonstrated to Student: **Yes ___ No ____**	**Other concerns/restrictions:**
Parent Signature:	
M.D. Signature (or med. Authorization form):	
Contact Information:	
Parent/Guardian: 1._ _____ 2._____	**Home phone:** Work:__ _____ Cell:_____ Work: Cell:_____
Home Address:	
Emergency contact:	
Primary Care Physician:	
Specialty MD:	**Phone**:
School Nurse:	**Phone**:
Preferred Hospital:	

*** If you believe your child does not need to keep an inhaler at school, please read the following information, sign and return to school as soon as possible.

☐ My child has been diagnosed with Asthma but he/she does **NOT** need to keep an inhaler at school at this time. By signing this form I acknowledge that the school nurse has cautioned me about having a Plan of Action to deal with signs and symptoms related to Asthma as well as keeping a rescue medication at school (when recommended by your child physician). **I understand that in case of a medical emergency or whenever the school is unable to reach me, the school will contact emergency services**.

Parent Signature _____ Date _____

Copies:
- □ Parent
- □ Teacher
- □ PE
- □ Transportation
- □ Clinic

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