BOYERTOWN AREA SCHOOL DISTRICT ASTHMA ACTION PLAN

Student Name_____ DOB_____ Gr/Hm_____

Severity Classification: □Intermittent □Mild Persistent □Moderate Persistent □Severe Persistent

Known Triggers**:** □ exercise □ allergies □ warm/cold weather □ respiratory infections □pollen

□pet dander □dust mites □smoke □fumes □ other_____

Parent/Guardian_____ Contact number_____

Alternate Emergency Contact_____Contact Number_____

Health Care Provider_____Contact number_____

Exercise pretreatment □Not Required □Before Recess □Before PE/Sport

Medication to be provided 15 minutes before activity: _____

Dose: _____Frequency_____Side effects: _____

_____

Green Zone: Doing Well

Symptoms: No cough, wheezing, chest tightness, or shortness of breath during the day or night, can work, exercise and play.

Takes controlled medicines <u>every day at home:</u>

Medication_____Dose_____Fequency_____

Medicaiton_____Dose_____Fequency_____

_____

Yellow Zone: Requires everyday medication and ADDING a rescue/ quick relief medication

Symptoms: cough, wheezing, short of breath, tightness in chest, cannot play/work easily, wake at night.

Peak Flow is between_____and _____, if used.

Medication_____Dose_____Frequency_____

Medication_____Dose_____Frequency_____

If symptoms persist for 20 minutes after the above treatment (s), parent will be notified for further care.

Red Zone: Call parent/guardian or alternate emergency contact and 911 immediately

Symptoms**:** Failure of medication to reduce worsening symptoms within 15-30 min, difficulty breathing, walking and/or talking, Blue or gray discoloration of the lips or fingertips and or, medication is not available, ineffective, or student unable to self-administer.

_____

___* I believe this child has demonstrated the skills or responsibility to carry and self- administer their inhaler during the regular school day, on field trips, and at extra-curricular activities upon clearance by their physician, , parent, and nurse; including when to tell an adult if symptoms do not improve after taking the medicine.

PHYSICIAN's SIGNATURE_____DATE_____

A Parent/ guardian signature are required: Please complete back side of this Action Plan

I, the parent/guardian of _____ request that the Boyertown Area School District nurse administer the above named medication as prescribed by my child's physician. My signature on this document constitutes a complete waiver of liability claim in any and all respects against the Boyertown Area School District and its Board of Directors and all employees unless the District is negligent with regard to any claim for injury in connection with administration of the prescribed medication.

Additionally, I agree to hand deliver the medication to the nurse's office in the original pharmacy or physician labeled container. I also accept responsibility to provide a physician's note and my written instructions if the medication is to be changed or discontinued. I give permission for the school and physician to communicate regarding this medication and medical condition.

____* I believe my child is able and responsible to carry and self-administer his/her inhaler during the regular school, on field trips, and at extra-curricular activities (Grades K-12)

PARENT /GUARDIAN SIGNATURE_____DATE_____

I give permission for the release and exchange of information between the nursing staff and my child's health care provider concerning my child's health and medications. In addition, I understand that this information will be shared with school staff on a need to know basis.

DATE_____PARENT/GUARDAN SIGNATURE_____

***REMINDER: All Action Plans and Medications require a yearly renewal while your child is under School Jurisdiction.**

INDIVDUAL HEALTH CARE PLAN

ASSESSMENT: Student exhibiting signs of respiratory distress, coughing, wheezing, SOB, unable to speak without losing breath.

NURSING DIANOSIS: Ineffective airway clearance related to inflammation, increased secretions.

GOAL: Maintain patent airway

NURSING INTERVENTION: Allow position of comfort -- sitting position. Promote rest. Maintain patent airway. Monitor vital signs, including pulse oximeter. Implement measures to reduce anxiety and apprehension. Use prescribed medications in compliance with the BASD medication policy. Student will have inhaler available if permitted to self-administer. Follow Asthma Emergency Action Plan. Encourage control breathing (in through nose, out through pursed lips (slowly) If symptoms improve, allow student to return to class. Contact parent per health room protocol. Call 911 if no improvement of symptoms.

EXPECTED OUTCOMES: Student will have action plan on file in health room. Student will have relief of symptoms with treatment provided by physician order and action plan. Student will have medication available as prescribed by physician. The student will demonstrate proper technique of self-medication and self-administer checklist will be completed. If the student is permitted to carry and self-administer medication, they will be responsible to report to the nurse if there is no improvement or symptoms.