Asthma Action Plan for Home & School

Name: Birthdate:

Asthma Severity: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

☐ He/she has had many or severe asthma attacks/exacerbations

☺ Green Zone

Have the child take these medicines every day, even when the child feels well.

Always use a spacer with inhalers as directed.

Controller Medicine(s): _____

_____

Controller Medicine(s) Given in School: _____

Rescue Medicine: Albuterol/Levalbuterol _____ puffs every four hours as needed

Exercise Medicine: Albuterol/Levalbuterol _____ puffs 15 minutes before activity as needed

😐 Yellow Zone

Begin the sick treatment plan if the child has a cough, wheeze, shortness of breath, or tight chest. Have the child take all of these medicines when sick.

Rescue Medicine: Albuterol/Levalbuterol _____ puffs every 4 hours as needed

Controller Medicine(s):

☐ Continue Green Zone medicines: _____

☐ Add: _____

_____

☐ Change: _____

If the child is in the **yellow** zone more than **24** hours or is getting worse, follow **red** zone and call the doctor right away!

☹ Red Zone

If breathing is hard and fast, ribs sticking out, trouble walking, talking, or sleeping.

Get Help Now

Take rescue medicine(s) now

Rescue Medicine: Albuterol/Levalbuterol _____ puffs every _____

Take: _____

_____

If the child is not better right away, call 911

Please call the doctor any time the child is in the red zone.

Asthma Triggers: (List)

School Staff: Follow the Yellow and Red Zone plans for rescue medicines according to asthma symptoms.
Unless otherwise noted, the only controllers to be administered in school are those listed as "given in school" in the green zone.

☐ Both the asthma provider and the parent feel that the child may carry and self-administer their inhalers

☐ School nurse agrees with student self-administering the inhalers

Asthma Provider Printed Name and Contact Information:	Asthma Provider Signature: Date:

Parent/Guardian: I give written authorization for the medications listed in the action plan to be administered in school by the nurse or other school members as appropriate. I consent to communication between the prescribing health care provider/clinic, the school nurse, the school medical advisor and school-based health clinic providers necessary for asthma management and administration of this medication.

Parent/guardian signature: Date:	School Nurse Reviewed: Date:

Please send a signed copy back to the provider listed above.

EMERGENCY ACTION PLAN

Anaphylaxis – Life-Threatening Allergies

Student Name: _____ DOB: _____ Grade: _____

Identified Allergen(s): _____

Asthma: ☐ Yes ☐ No Other relevant health concerns: _____

Student Picture

Contact Information:

Parent/Guardian Name: _____ Phone: _____

Parent/Guardian Name: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Additional Contacts: _____ Phone: _____

Building Health Office/School Nurse: _____ Phone: _____

IMPORTANT: EACH ALLERGIC REACTION MAY INCREASE IN SEVERITY FROM PREVIOUS REACTIONS.
ALLERGIC REACTIONS CAN INCREASE IN SEVERITY QUICKLY – PROVIDE EMERGENCY CARE AS QUICKLY AS POSSIBLE

A LIFE-THREATENING ALLERGIC REACTION MAY INCLUDE ANY OR ALL OF THESE SYMPTOMS:

Are any of these signs and symptoms present and severe?

- ✓ LUNG: Short of breath, wheeze, repetitive cough
- ✓ HEART: Pale, blue, faint, weak pulse, dizzy, confused
- ✓ THROAT: Tight, hoarse, trouble breathing/swallowing
- ✓ MOUTH: Obstructive swelling (tongue and/or lips)
- ✓ SKIN: Hives over body

Or is there a combination of symptoms from different body areas?

- ✓ SKIN: Hives, itchy rashes, swelling (eyes, lips)
- ✓ GUT: Vomiting, cramping pain, diarrhea
- ✓ RESPIRATORY: Runny nose, sneezing, swollen eyes, phlegmy throat
- ✓ OTHER: Confusion, agitation, feeling of impending doom

DO THIS

INITIATE CARE – do not delay treatment if anaphylaxis is suspected. When in doubt, give epinephrine.

TREATMENT: Epinephrine – Medication is at school ☐ Yes ☐ No Dosage: _____

Directions for administration: _____ ☐ Repeat dose after 5 or more minutes if needed.

☐ Treatment should be initiated immediately following exposure without waiting for symptoms (per healthcare provider).

☐ Treatment should be initiated only following the appearance of symptoms (per healthcare provider).

THEN MONITOR

PROVIDE ONGOING CARE: Stay with the student, maintain airway, do not have the student rise to an upright position. Observe for changes.

If epinephrine is given, call 911 immediately and transport the student to the nearest emergency room.

Preferred hospital: _____

Doctor's Name: _____ Date: _____

Emergency Plan written by: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

The parent/guardian signature authorizes the nurse to share this information with school staff on a "need to know" basis.
In the event of an emergency, care will be initiated and parents will be contacted.

This plan is in effect for the current school year only.

EMERGENCY ACTION PLAN

Hypoglycemia – Diabetes

Student Name: _____ DOB: _____ Grade: _____

Student Picture

Contact Information:

Parent/Guardian Name: _____ Phone: _____

Parent/Guardian Name: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Additional Contacts: _____ Phone: _____

Building Health Office/School Nurse: _____ Phone: _____

AN EPISODE OF HYPOGLYCEMIA MAY INCLUDE ANY OR ALL OF THESE SYMPTOMS:

Are any of these signs and symptoms present and severe?

✓ Shaking
✓ Fast heartbeat
✓ Sweating
✓ Anxiety, irritability

Onset may be sudden and can progress to a life threatening low blood sugar. If untreated seizures and even death can occur.

DO THIS – do not delay treatment.

TREATMENT: Stop any activity. Do not leave the student alone.
Accompany the student to the Health Office for treatment, if possible (blood glucose and monitoring).
Access assistance from the school nurse, if possible.

Proceed with the following care per healthcare provider's instructions:

☐ Give snack: ½ to ¾ cup juice, 3 – 4 glucose tabs, or hard candy.
☐ Give glucose gel for emergency care.
☐ Give glucagon if unresponsive, unable to swallow, or unable to follow directions. After glucagon is given, call 911.

Glucagon should be given without delay if student is unconscious or experiencing a seizure

Location of student's glucagon: _____ Route (injection or intranasal): _____

Site on body for glucagon if given by injection: _____

Staff member(s) trained by school nurse to administer glucagon to this student: _____

_____

Call parents as soon as possible. Have a staff member accompany the student to medical care if needed – do not leave the student unattended. If on a field trip, notify the school nurse at: _____

If glucagon is given, call 911 immediately and transport the student to the nearest emergency room.

Preferred hospital: _____

Doctor's Name: _____ Date: _____

Emergency Plan written by: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

The parent/guardian signature authorizes the nurse to share this information with school staff on a "need to know" basis. In the event of an emergency, care will be initiated and parents will be contacted.

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EMERGENCY ACTION PLAN

Sickle Cell Disease - Pain (Vaso-occlusive) Crisis

Student Name: _____ DOB: _____ Grade: _____

Student Picture

Contact Information:

Parent/Guardian Name: _____ Phone: _____

Parent/Guardian Name: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Additional Contacts: _____ Phone: _____

Building Health Office/School Nurse: _____ Phone: _____

A pain crisis is when the blood vessels get blocked by sickled red blood cells and the tissues don't get the oxygen they need. A pain crisis can come on suddenly or build up over a few days.

A PAIN CRISIS MAY INCLUDE ANY OR ALL OF THESE SYMPTOMS:

Are any of these signs and symptoms present?

- ✓ Pain or discomfort
- ✓ Headache (severe)
- ✓ Chest pain
- ✓ Bone/joint/hip pain
- ✓ Upper left, abdominal pain
- ✓ Priapism (sustained, unwanted erection)
- ✓ Vomiting
- ✓ Swelling of hands or feet

TREATMENT: Initiate care – do not delay treatment. Stop any activity. Accompany the student to the Health Office for treatment, if possible. Access assistance from the school nurse, if possible. **Never apply ice.**

Medical Emergency - Contact the School Nurse

- ✓ Fever 101 degrees or higher
- ✓ Weakness or fatigue
- ✓ Weakness on either side of body
- ✓ Inability to speak
- ✓ Difficulty with memory
- ✓ Sudden or constant dizziness
- ✓ Blurred vision
- ✓ Changes in breathing, difficulty breathing, fast rate or harsh noisy breathing
- ✓ Noticeable change in the color of the skin, lips, fingernails

TREATMENT: For medical emergencies, the school nurse is unavailable call 911 immediately and transport the student to the nearest emergency room.

Preferred hospital: _____

Doctor's Name: _____

Phone: _____

Proceed with the following care per healthcare provider's instructions:

❑ Medication _____ ❑ Hydrate: _____ Other: _____

Emergency Plan written by: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

The parent/guardian signature authorizes the nurse to share this information with school staff on a "need to know" basis. In the event of an emergency, care will be initiated and parents will be contacted.

This plan is in effect for the current school year only.

EMERGENCY ACTION PLAN

Seizures

Student Name: _____ DOB: _____ Grade: _____

Student Picture

Contact Information:

Parent/Guardian Name: _____ Phone: _____

Parent/Guardian Name: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Additional Contacts: _____ Phone: _____

Building Health Office/School Nurse: _____ Phone: _____

Seizure Type	Triggers	How Long it Lasts	How Often	What Happens

First Aid - STAY calm, begin timing seizure. Notify school nurse.

- ✓ Provide PRIVACY – remove other students from area
- ✓ Keep the student SAFE – remove harmful objects, don't restrain, protect head.
- ✓ Position on SIDE – turn on side if not awake, keep airway clear, do not put objects in mouth

Give Medication or Treatment

- ✓ Administer Medication: _____ Instructions: _____
- ✓ Swipe magnet for VNS (Vagal Nerve Stimulator) Instructions: _____

Get Help If:

- ✓ Lasts more than 5 minutes
- ✓ Repeated seizures longer than 10 minutes with no recovery time in-between
- ✓ Seizure does not stop after giving emergency medication
- ✓ Difficulty breathing after seizure ends
- ✓ Serious injury occurs or suspected, or seizure in water

After the Seizure

- ✓ **STAY with the student until fully recovered from seizure**
- ✓ Notify parent or guardian if student does not return to usual behavior (i.e., confused, or lethargic).

Emergency Plan written by: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

The parent/guardian signature authorizes the nurse to share this information with school staff on a "need to know" basis. In the event of an emergency, care will be initiated and parents will be contacted.

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EMERGENCY ACTION PLAN

Health Condition _____

Student Name: _____ DOB: _____ Grade: _____

Student Picture

Contact Information:

Parent/Guardian Name: _____ Phone: _____

Parent/Guardian Name: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Additional Contacts: _____ Phone: _____

Building Health Office/School Nurse: _____ Phone: _____

AN EMERGENCY MAY INCLUDE ANY OR ALL OF THESE SYMPTOMS:

_____

If you see this:	DO THIS:

Preferred hospital: _____

Doctor's Name: _____ Date: _____

Emergency Plan written by: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

The parent/guardian signature authorizes the nurse to share this information with school staff on a "need to know" basis. In the event of an emergency, care will be initiated and parents will be contacted.

This plan is in effect for the current school year only.