ST. MARY'S COUNTY PUBLIC SCHOOLS

Department of Student Services/ Health Department

ASTHMA EMERGENCY ACTION PLAN
MEDICATION ADMINISTRATION AUTHORIZATION

Trigger (List)

_____

_____

_____

_____

Asthma Action Plan ___/___/___ to ___/___/___ (not to exceed 12 months)

Student's Name: _____ D.O.B.: _____ Peak Flow Personal Best: _____

Parent(s)'/Legal Guardian(s)' Name: _____ Home: _____ Work: _____ Cell: _____

Asthma Severity: ☐ Exercise Induced ☐ Intermittent ☐ Mild Persistant ☐ Moderate Persistent ☐ Severe Persistent

Check Symptoms/Indications for Medication Use

Green Zone — **Controller Medication – Use Daily at Home Unless Otherwise Indicated.**

☐ Breathing is good
☐ No cough or wheeze
☐ Can work, exercise, play
☐ Other: _____
☐ Peak flow greater than _____ (80% personal best)

Medication	Dose	Route	Frequency/Time
			☐ School
			☐ School
			☐ School

Exercise Zone

☐ Prior to exercise/sports/physical education (PE)

Medication (Rescue Medication)	Dose	Route	Frequency/Time

If using more than twice per week for exercise/sports/PE, notify the health care provider and parent(s)/legal guardian(s).

Yellow Zone — **Rescue Medications - To Be Added to Green Zone Mediations for Symptoms.**

☐ Cough or cold symptoms
☐ Wheezing
☐ Tight chest or shortness of breath
☐ Cough at night
☐ Other: _____
☐ Peak flow between _____ and _____ (50%-79% personal best)

Medication	Dose	Route	Frequency/Time

If symptoms do not improve in _____ minutes, notify the health care provider and parent(s)/legal guardian(s).
If using more than twice per week, notify the health care provider and parent(s)/legal guardian(s).

Red Zone — **Emergency Medications - Take these Medications and Call 911.**

☐ Medication is not helping within 15-20
☐ Breathing is hard and fast
☐ Nasal flaring or intercostal retraction
☐ Lips or fingernails blue
☐ Trouble walking or talking
☐ Other: _____
☐ Peak flow less than _____ (50% personal best) _____

Medication	Dose	Route	Frequency/Time

Contact the parent(s)/legal guardian(s) after calling 911.

Health Care Provider Authorization
I authorize the administration of the medications as ordered above.
Student may self-carry medications ☐ Yes ☐ No
Health Care Provider Name: _____
Signature: _____
Date: _____

Parent(s)/Legal Guardian(s) Authorization
I authorize the administration of the medications as ordered above.
I acknowledge that my child ☐ is ☐ is not authorized to self carry his/her medication(s):
Signature: _____
Date: _____

Reviewed by School Nurse
Name: _____
Signature: _____
Date: _____
Authorized to self-carry medications: ☐ Yes ☐ No

ST. MARY'S COUNTY PUBLIC SCHOOLS

Department of Student Services/ St. Mary's County Health Department

ASTHMA EMERGENCY ACTION PLAN
MEDICATION ADMINISTRATION AUTHORIZATION (CONTINUED)

Emergency Response Information

Student's Name: _____ D.O.B.: _____

Parent/Legal Guardian **#1**: _____ Parent/Legal Guardian **#2**: _____

Home Phone: _____ Home Phone: _____

Work Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Phone: _____

Emergency Contact: _____ Phone: _____

Emergency Medication: ☐ No ☐ Yes (Name) _____

Physician's Name: _____ Physician's Phone #: _____

Parent(s)'/Legal Guardian(s)' Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____

Reviewed by: _____ Date: _____

Reviewed by: _____ Date: _____

Reviewed by: _____ Date: _____

Reviewed by: _____ Date: _____

Reviewed by: _____ Date: _____

Reviewed by: _____ Date: _____

Reviewed by: _____ Date: _____

Reviewed by: _____ Date: _____

Reviewed by: _____ Date: _____

Reviewed by: _____ Date: _____

Trained Staff Members

1. _____ Room _____
2. _____ Room _____
3. _____ Room _____
4. _____ Room _____
5. _____ Room _____
6. _____ Room _____

Metered Dose Inhaler Direction

1. Make sure the inhaler is free of foreign objects. Shake the inhaler for 10 seconds to mix the medicine. Remove the cap from the mouthpiece.
2. Stand up, take a deep breath in, and breathe out as much as you can.
3. Open your mouth with the inhaler 1 to 2 inches away. Hold the inhaler between your index finger and thumb.
4. With mouth open, take a slow, deep breath (for about 5 seconds) through your mouth while, at the same time, firmly pressing down on the canister to release the medicine.
5. Hold your breath for 5 to 10 seconds, with your mouth closed.
6. Breathe out slowly through your mouth.
7. Wait 1 minute before taking a second puff, if directed. Repeat steps 1 through 6 if taking a second puff.