Scurry-Rosser Independent School District
Student Asthma Action Plan

Student Name:_____ **Grade:**_____ **ID #:** _____

Physician Name: _____ **Office Number:** _____

Emergency Contact: _____ **Phone Number:** _____

Best Peak Flow: _____ **Known Triggers:** _____

Daily Asthma Medications: _____

Green Zone

Good to Go Zone ~ Breathing is good * No cough or wheeze * Can work or play

Peak Flow _____ to _____

Use _____ inhaler/nebulizer _____ puffs _____ minutes before sports or PE.

Yellow Zone

Caution Zone ~ Coughing * Wheezing * Tight chest * Shortness of breath

Peak Flow _____ to _____ ***Use Reliever Medication***

Use _____ inhaler/nebulizer _____ puffs every _____ minutes until relief or if symptoms continue call parents to pick up and consult Physician.

Red Zone

I Need Help Zone ~ Medicine not helping * Breathing hard & fast * Can't walk
Can't talk well

Peak Flow _____ to _____ ***Call Physician NOW!***

Use _____ inhaler/nebulizer _____ puffs every _____ minutes until receive further orders from physician.

I have reviewed the above asthma action plan and instructed the student and parent on the use of the prescribed medication.

☐ I have instructed the student in the proper way to use his/her asthma medication. It is my professional opinion that he/she should be allowed to carry &/or self-administer the medication while on school property or at school-related events.

☐ Student does not need to carry inhaler, but it should be available in the health office.

Physicians Signature:_____ Date:_____

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Dear Parent/Legal Guardian:

The health and safety of your child is very important to us. On your child's health information sheet you indicated he/she has asthma. Please take the time to fill out the bottom of this form, and have your child's physician fill out the Asthma Action Plan on the back of this form.

Please return the form and any necessary emergency medication to the nurse's office as soon as possible.

Your child's teachers will be updated on their condition and will allow them to come to the nurse's office for evaluation/treatment when needed.

If you have any questions or concerns please feel free to contact the health office.

Student's Name:_____ **Grade:** _____ **ID #:** _____

I hereby give permission for my child to receive medication at school as prescribed in the Asthma Action Plan. Medication must be provided in its original prescription container properly labeled by a pharmacist or physician. I also give permission for the release and exchange of information between the school nurse 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.

Parent/Guardian Signature:_____**Date:**_____

Daytime Phone Number:_____

Emergency Contact: _____

Phone Number: _____

Emergency Contact: _____

Phone Number:_____