Student Asthma Action Plan

Name_____ Age_____

Parent/guardian_____ Phone 1_____ Phone 2_____

Healthcare provider_____ Phone_____ Fax/Email: _____

Green Zone	**Patient is feeling well** • No difficulty participating in usual activities • No chest tightness, shortness of breath, wheezing, or coughing during the day or night <u>Take these controller medications every day:</u> Name Dose When to take it _____ _____ <u>Before exercise:</u> Medication _____ Dosage _____ ____minutes prior to activity
Yellow Zone	Patient is not feeling well • Chest tightness, shortness of breath, wheezing, or coughing with usual activities • Waking at night due to asthma symptoms <u>Continue taking controller medication(s) and add these quick-relief medications:</u> Name Dose When to take it _____ _____ Call child's healthcare provider if: _____ _____
Red Zone	**Alert! Contact patient's healthcare provider or call 911 if:** • Quick-relief medication is not helping • Breathing is hard and fast • Ribs are showing and nostrils are flaring • Can't walk or talk well <u>Take the following medications, and call the child's healthcare provider or 911 right away:</u> Medicine Dose When to Take it _____ _____

Other key medical information

Child's asthma triggers, and other useful information: _____

_____

Reviewed by parent/guardian _____ Date _____

Reviewed by child's healthcare provider _____ Date _____

Montana Authorization to Possess or Self-Administer Asthma, Severe Allergy, or Anaphylaxis Medication

For this student to possess or self-administer asthma, severe allergy, or anaphylaxis medication while in school, while at a school-sponsored activity, while under the supervision of school personnel, before or after normal school activities (such as while in before-school or after-school care on school-operated property), or while in transit to or from school or school-sponsored activities, this form must be fully completed by 1) the prescribing physician/physician assistant/advanced practice registered nurse, and 2) an authorizing parent, an individual who has executed a caretaker relative educational or medical authorization affidavit, or legal guardian.

Student's Name:_____ School:_____
Sex: (Please circle) Female / Male City/Town: _____
Birth Date: _____/_____/_____ School Year: _____(Must be renewed annually)

Authorization by Physician/PA/APRN:

The above-named student has my authorization to carry and self administer the following asthma, severe allergy, or anaphylaxis medication:
Medication: (1)_____ Dosage: (1) _____

(2) _____ (2) _____

Reason for prescription(s): _____
Medication(s) to be used under the following conditions (times or special circumstances):
_____
_____

I confirm this student has been instructed in the proper use of this medication and is able to self-administer this medication without school personnel supervision. I have formulated and provided to the parent/guardian or caretaker relative a written treatment plan for managing asthma, severe allergies, or anaphylaxis episodes and for medication use by this student during school hours and school activities.

_____ _____ _____
Signature of Physician/PA/APRN Phone Number Date

Authorization by parent, individual who has executed a caretaker relative educational or medical authorization affidavit, or guardian:

As the parent, individual who has executed a caretaker relative educational or medical authorization affidavit, or guardian of the above named student, I confirm this student has been instructed by his/her health care provider on the proper use of this/these medication(s). He/she has demonstrated to me he/she understands the proper use of this medication. He/she is physically, mentally, and behaviorally capable to assume this responsibility. He/she has my permission to self-medicate as listed above, if needed. If he/she has used epinephrine during school hours, he/she understands the need to alert the school nurse or other adult at the school who will provide follow-up care, including making a 9-1-1 emergency call.

I acknowledge the school district or nonpublic school and its employees and agents are not liable as a result of any injury arising from the self-administration of medication by the student, and I indemnify and hold them harmless for such injury, unless the claim is based on an act or omission that is the result of gross negligence, willful and wanton conduct, or an intentional tort.

I agree to work with the school in establishing a plan for use and storage of backup medication. This will include a predetermined location to keep backup medication to which the student has access in the event of an asthma, severe allergy, or anaphylaxis emergency. I have provided the following backup medication: _____

I understand in the event the medication dosage is altered, a new "self-administration form" must be completed, or the health care provider may rewrite the order on his/her prescription pad and I, the parent/caretaker relative/guardian, will sign the new form and assure the new order is attached.

I understand it is my responsibility to pick up any unused medication at the end of the school year, and any medication not picked up will be disposed of.

I authorize the school administration to release this information to appropriate school personnel and classroom teachers.

Parent/Caretaker/Guardian relative signature: _____ Date: _____

(Original signed authorization to the school; a copy of the signed authorization to the parent/guardian and health care provider)
See generally Mont. Code Ann. § 20-5-420