Desoto Independent School District
Health Services 2019-2020
Asthma Action Plan

Student Name:____ **DOB:** ________________ **Grade:** ________

Daily Asthma Medications: ____

Best Peak Flow (if applicable): ________________ Emergency contact:____

Known Triggers (circle all that apply): pollen mold dust cold/flu smoke weather changes

exercise animals pollution strong odors other: __________________________

~ "Good to Go" Zone ~

Breathing is good * No cough or wheeze * Can work or play with ease*

Peak Flow ________ to ________

1. Continue using daily preventative medication as prescribed.
2. Use ______________________ inhaler/nebulizer _____ puffs/vials _____ minutes before sports or PE.

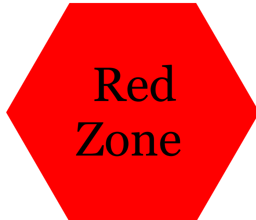
~ "Caution" Zone ~

****Coughing * Wheezing * Tight chest * Shortness of breath****

Peak Flow ________ to ________

Use Reliever Medication*

1. Use ______________________ inhaler/nebulizer _____ puffs/vials every _____ hours as needed.
2. If symptoms continue, refer to Red Zone, call parents to pick up, and consult provider.



~ "I Need Help" Zone ~

****Medicine not helping * Breathing hard & fast * Can't walk or talk well****

Peak Flow ________ to ________

Call Physician or 911 NOW!*

1. Use ______________________ inhaler/nebulizer _____ puffs/vials every _____ minutes until receive further orders from physician.
2. Notify parent and/or call EMS.

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

________ (Initial if applicable) I have instructed the student in the proper way to use their asthma medication. It is my professional opinion that they should be allowed to carry &/or self-administer the medication while on school property or at school-related events.

________ (Initial if applicable) Student **does not** need to carry inhaler, but it should be available in the health office.

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Physician/Healthcare Provider Signature:____ Date: ____________

Physician Printed Name and Telephone Number: ____

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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 they have asthma. Please take the time to fill out the bottom of this form and have your child's physician or other healthcare provider fill out the Asthma Action Plan on the back of this form.

Please return the form and any necessary emergency medication (i.e. albuterol) 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 your campus nurse.

Student's Name:__________________________________ **Grade:** ____ **ID #:** ____________________________

I hereby give permission to the school nurse or school personnel designated by the principal to administer medication to my child as prescribed in the Asthma Action Plan. Alternatively, I give permission for my child to carry and self-administer prescribed emergency medication if cleared by their healthcare provider as noted 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 to this, I understand that this information will be shared with school staff as deemed appropriate for my child's health and safety. I understand that this permission is valid for the duration of the school year unless the nurse is informed by my child's provider or myself that it has been discontinued and I understand that changes to medication require a new action plan to be completed.

Parent/Guardian Signature:____**Date:**_______________

Printed Name: ____

Daytime Phone Number: ____

Emergency Contact: ____

Phone Number: ____

Emergency Contact: ____

Phone Number:____