Convent of the Visitation School

## *Health Office*

Dear Parent,

The Visitation Health Staff wants to promote a positive and healthy learning environment for each student.

According to our records your child is listed as having asthma or an asthmatic like condition. With your help we would like to make a plan for any necessary adjustments during the school day for your child. The intent of this plan is to promote wellness, with control of his/her asthma.

**Please complete the asthma forms found online and return them to the health office as soon as possible. This information will be requested yearly and will be kept in your child's Health Record in the Health Office.**

All use of inhalers in school requires a written order from the physician or licensed prescriber. Asthma inhalers will be kept in the school's Health Office unless otherwise indicated.

If you wish for your student to keep his/her asthma inhaler with him/her, then these criteria must be met:

1) The parent must give written permission.

2) The inhaler must be properly labeled for that specific student.

3) The student must demonstrate appropriate use of the inhaler.

4) A written order must be received from the physician or licensed prescriber.

If your child no longer has asthma symptoms, please return the physician form, indicating that change, and we will update your child's school health record.

Thank you for your time in assisting us to promote health and safety for your child.

Sincerely,

Health Office Staff
Convent of the Visitation School
651-683-1708

Convent of the Visitation School

*Health Office*

# Asthma Action Plan

Student's Name: _____ Date of Birth: _____ Student's Weight: _____

Primary Care Clinic Name: _____ Phone number: (_____)_____

Primary Care Provider Name: _____ Phone number: (_____)_____

Symptom Triggers: _____

- ❑ This authorization may replace or supplement the school's Consent for Medication Administration Form and allows my child's medicine to be administered at school.
- ❑ My child (circle one): **may** **may not** carry, self-administer, and use rescue medication at school after approval by the School Nurse as appropriate.
- ❑ I understand that this authorization form is valid for one school year, *but may be revoked at any time per my request*. (A revocation must be submitted, by phone or in writing, directly to the Visitation Health Office).
- ❑ I give my permission for this asthma action plan to be used by the following people in order to share information with each other about my child's asthma.

(*Write in names for those categories that are applicable*)

- ❑ MD/NP/PA: _____
- ❑ Coach(es): _____
- ❑ Day Care Provider: _____
- ❑ Clinic/Hospital: _____
- ❑ School/School Health Office: _____
- ❑ Other: _____

_____ _____ (_____)_____

Parent/Guardian Signature Date Phone Number

**Physician: Please fill out both Page 1 and Page 2 of this Asthma Action Plan**

Student's Peak Flow: _____ Asthma Severity: _____

**Symptom Triggers**: _____

- ❑ This Asthma Action Plan provides authorization for the administration of medications described in the AAP.
- ❑ This child has the knowledge and skills to self-administer rescue medication at school.
- ❑ I have completed the back of this form (Green, Yellow, Red Zone information).

_____ _____ **(**_____**)**_____

**MD/NP/PA Signature** **Date** **Phone Number**

# Asthma Action Plan – Physician Form: Page 2 of 2

**(Both pages are to be completed by student's physician)**

## Green Zone

"GO! All Clear"

*Peak Flow Range:*

_____ to _____

(80-100% of personal best)

-Breathing is easy

-Can play, work, and sleep without asthma symptoms

The **Green Zone** means take the following medicine(s) every day:

| Controller Medicine(s) | Dose |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Spacer Used: _____

Take the following medicine, if needed, 10-20 minutes before sports, exercise, or any other strenuous activity:

_____

## Yellow Zone

"Caution…"

*Peak Flow Range:*

_____ to _____

(50-80% of personal best)

-Wake up at night

-Cough or wheeze

-Chest is tight

The **Yellow Zone** means you should keep taking your **Green Zone** controller medicine(s) every day, and also add the following medicine(s) to help keep the asthma symptoms from getting worse:

| Reliever Medicine(s) | Dose |
|---|---|
| _____ | _____ |
| _____ | _____ |

**If beginning cold symptoms, call your doctor before starting oral steroids.**

**Use Quick Reliever, 2-4 puffs, every 20 minutes for up to 1 hour or use nebulizer once. If your symptoms are not better or you do not return to the Green Zone after 1 hour, follow Red Zone instructions.**

**If you are in the Yellow Zone for more than 12-24 hours, call your doctor. If your breathing symptoms get worse, call your doctor.**

## Red Zone

"STOP!"

*Peak Flow Range:*

_____ to _____

(Below 50% of personal best)

-Medicine is not helping

-Nose opens wide to breathe

-Breathing is hard and fast

-Trouble Walking

-Trouble Talking

-Ribs show

The **Red Zone** means start taking your **Red Zone** medicine(s) AND call your Doctor NOW!

Take these medicines until you talk with your doctor:

| Reliever Medicine(s) | Dose |
|---|---|
| _____ | _____ |
| _____ | _____ |

**If your symptoms do not get better and you can't reach your doctor, go to the emergency room or call 911 immediately!**

**Student Name:** _____

_____ _____

**MD/NP/PA Signature** **Date**