NEW MEXICO ASTHMA ACTION PLAN FOR SCHOOLS

Date_____

School District Test _____ School Name _____

School Nurse / Health Asst. _____ School Phone # / FAX # _____ /_____

PARENT/GUARDIAN: Please complete the information in the top sections and sign consent at bottom of the page.

Student Name	**Date of Birth**	**Student #**
***Health Care Provider Name/Title**	**Provider's Office Phone / FAX #**	
Parent/Guardian	**Parent's Phone #s**	
Emergency Contact	**Contact Phone #s**	
Allergies to Medications:		

Date of last medical exam: ___/___/_____	**Inhaler is kept:** ☐ with student ☐ Health Office ☐ Classroom ☐ Other: _____
Date of last Flu Shot: ___/___/_____	**Inhaler expires on:** ___/___/_____

Asthma Triggers Identified (Things that make your asthma worse):

☐ Exercise ☐ Colds ☐ Smoke (tobacco, fires, incense) ☐ Pollen ☐ Dust ☐ Strong Odors ☐ Mold/moisture ☐ Stress ☐ Pests (rodents, cockroaches) ☐ Gastroesophogeal reflux ☐ Season: Fall, Winter, Spring, Summer ☐ Animals ☐ Other (food allergies):_____

HEALTH CARE PROVIDER: Please complete Severity Level, Zone Information and Medical Order Below

Asthma Severity: ☐ Intermittent *or* Persistent: ☐ Mild ☐ Moderate ☐ Severe

HEALTHY *(Green Zone)*: You're Doing Well - Take Control Medications EVERYDAY to Prevent Symptoms

You have **ALL** of these:

- Breathing is good
- No cough or wheeze
- Can work and play
- Sleep through the night

- *Inhalers work better with spacers*
- *Always use a mask when prescribed*

☐ ***No** controller medication is prescribed.*

☐ _____, _____ puff(s) MDI _____ times a day

☐ _____, _____nebulizer treatment(s) _____ times a day

☐ _____ _____

If exercise triggers your asthma, take:

_____, _____ puff(s) MDI _____ minutes before exercise every _____ hours PRN

CAUTION *(Yellow Zone)*: Slow Down! Continue Green Zone Medicine and ADD:

You have ***ANY*** of these:

- First signs of a cold
- Cough or mild wheeze
- Exposure to known trigger
- Tight Chest
- Coughing at night

DO NOT LEAVE STUDENT ALONE! Call Parent/Guardian when rescue medication is given.

☐ _____, _____ puff(s) every_____ minutes / hours PRN *(circle)*

OR

☐ _____, _____ **nebulizer** treatment(s) & every _____ minutes / hours PRN *(circle)*

*If you are **getting worse or not improving** after treatment(s) **GO TO RED ZONE***

EMERGENCY *(Red Zone)*: TAKE THESE MEDICINES NOW AND GET MEDICAL HELP NOW!

Your asthma is getting worse fast:

- Cannot talk, eat, or walk well
- Medicine is not helping
- Getting worse, not better
- Breathing hard & fast
- Getting nervous

DO NOT LEAVE STUDENT ALONE! Call 911 and start treatment then call Parent/Guardian.

Administer: _____, _____ puff(s) every_____ minutes until EMS arrives

☐ **For schools that stock Oxygen:** (Only use Oxygen if Pulse Oximeter available)
Give 02 to keep sat. above 92% unless otherwise contraindicated. Check sat. continually until EMS arrives.

HEALTH CARE PROVIDER ORDER AND SCHOOL MEDICATION CONSENT

Check all that apply:

____ Student has been instructed in the proper use of his/her asthma medications and IS ABLE TO CARRY AND SELF-ADMINISTER his/her INHALER AT SCHOOL.

____ Student is to notify school health personnel after using inhaler at school.

____ Student needs supervision or assistance when using inhaler.

____ Student is unable to carry his/her inhaler while at school.

***SIGNATURE/TITLE**: _____ **DATE**: _____

Parent/Guardian:

I approve of this asthma action plan. I give my permission for the school nurse and trained school personnel to follow this plan, administer medication(s), and contact my provider, if necessary, and share this plan with the SBHC, if applicable. I assume full responsibility for providing the school with the prescribed medications and delivery of monitoring devices. I give my permission for the school to share the above information with school staff that need to know and permission for my child to participate in any asthma educational learning opportunities at school.

SIGNATURE: _____ **DATE:**_____

SCHOOL NURSE: _____ **DATE:** _____

Asthma Action Plan for School Student–
Parent Instructions

The NM Asthma Action Plan for Schools is designed to help everyone understand the steps necessary for the individual student to achieve the goal of controlled asthma.

1. **Parents/Guardians:** *Before taking this form to your Health Care Provider*, complete the top section with:
   - Child's name
   - Child's doctor's name & phone number
   - Parent/Guardian's name
   - Child's date of birth
   - An Emergency Contact person's name & phone number

2. **Your Health Care Provider** will complete the following areas:
   - The asthma severity level of your child's asthma
   - The effective date of this plan
   - The medicine and dosage information for the Healthy, Caution and Emergency sections

3. **Parents/Guardians & Health Care Providers together** will discuss and then complete & sign the following areas:
   - Child's asthma triggers near the top of the form
   - Health care provider order and school medication consent section at the bottom of the form: Discuss your child's ability to self-administer the inhaled medications, check the appropriate box, and then both you and your Health Care Provider must sign and date the form

4. **Parents/Guardians:** *After completing the form with your Health Care Provider:*
   - Make copies of the Asthma Action Plan and give the signed original to your child's school nurse or child care provider
   - Keep a copy easily available at home to help manage your child's asthma
   - Give copies of the Asthma Action Plan to everyone who provides care for your child, for example: babysitters, before/after school program staff, coaches, scout leaders
   - Call your child's doctor for control concerns or if rescue medication is used more than 2 times per week for asthma symptoms

For asthma or any medical condition, seek medical advice from your child's or your health care professional.

FILL OUT THE SECTION BELOW IF YOUR HEALTH CARE PROVIDER CHECKED PERMISSION FOR YOUR CHILD TO SELF-ADMINISTER ASTHMA MEDICATION ON THE FRONT OF THIS FORM.
RECOMMENDATIONS ARE EFFECTIVE FOR ONE (1) SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY

☐ **I DO** request that my child be ALLOWED to carry the following medication _____ for self-administration in school pursuant to NMAC 6.12.2.9. I give permission for my child to self-administer medication, as prescribed in this NM Asthma Action Plan for Schools for the current school year as I consider him/her to be responsible and capable of transporting, storing and self-administration of the medication. Medication must be kept in its original prescription container. I understand that the school district, agents and its employees shall incur no liability as a result of any condition or injury arising from the self-administration by the student of the medication prescribed on this form. I indemnify and hold harmless the School District, its agents and employees against any claims arising out of self-administration or lack of administration of this medication by the student.

☐ **I DO NOT** request that my child self-administer his/her asthma medication.

_____ _____ _____
Parent/Guardian Signature | Phone | Date

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