WONEWOC-CENTER SCHOOLS ASTHMA HEALTH PLAN

Student_____ **Date of Birth**_____
Grade_____ **Teacher**_____ **School Year**_____
Parent/Guardian_____ **Phone Number**_____
Practitioner_____ **Phone Number**_____

Severity Classification: ☐ Intermittent (with illness) ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent
☐Student has had many or severe asthma attacks/exacerbations ☐ No longer a concern
Asthma Triggers_____

GREEN ZONE - DOING WELL! Breathing is good. No cough or wheeze. Can work and play.

Control Medicine(s)	Medicine	Number of Puffs	How Often/Frequency	Take at:
	_____	_____	_____	☐Home ☐School
	Medicine	Number of Puffs	How Often/Frequency	Take at:
	_____	_____	_____	☐Home ☐School

Physical Activity:
☐Use albuterol ____ puffs, 15 minutes prior to activity ☐with all activity ☐when he/she feels it is needed

YELLOW ZONE – CAUTION! Cough. Wheeze. Tight chest. Wake at night coughing.

Quick-relief Medicine(s) ☐ Albuterol ____ puffs, every 4 hours as needed OR 1 nebulizer treatment of_____
☐ Repeat after 20 minutes if needed (for a maximum of 2 treatments)
☐ Schedule up to 2 times per school day per parent request, at least _____ hours between treatments

Control Medicine(s) ☐Continue Green Zone medicines
☐Other _____

If you are in the **YELLOW ZONE** more than 24 hours or are getting worse, follow **RED ZONE** and call your doctor right away!

RED ZONE – MEDICINE IS NOT WORKING. GET HELP NOW!
Breathing is hard. Nostrils are open. Ribs are showing. Lips/fingernails gray or pale.

Take Quick-relief Medicine NOW ☐ Albuterol _____ puffs, every _____minutes/hours, for _____ treatments as needed
☐ Other _____

Ca11 911 Immediately if the following danger signs are present:

- Trouble walking/talking due to shortness of breath
- Lips or fingernails are blue
- Still in the red zone after 15 minutes

Continued on back

PARENT/GUARDIAN CONSENT:

- I request and authorize that this medication be administered by school personnel.
- I understand that medication may be given by non-medically trained school personnel.
- I will supply medication in its original, updated, properly labeled container. (Request extra bottle from pharmacist.)
- This order is in effect for this school year unless otherwise indicated.
- I will obtain a new physician's order and notify the school in writing for any changes.
- I authorize school personnel to exchange information verbally or in writing with my child's physician regarding this medication or the conditions for which it is prescribed.
- I further understand that all medication should be delivered to the school by parent/guardian.
- I will pick up unused medications at the end of the school year. Unclaimed medications will be discarded.
- I agree to hold the School District, its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.
- My signature indicates that I have fully read and understand the above information.
- This student is capable of self-administration and may carry inhaler and self-administer in school.
  ☐ Yes ☐ No

_____ _____

Signature of Parent/Legal Guardian Date

PHYSICIAN ORDER:

The above medication(s) is to be administered during the school day in accordance with the above instructions and agreements. I agree to accept communication about student/medication and understand the medication may be given by non-medically trained school personnel. Please contact me if the following symptoms occur:

_____

This student is capable of self-administration and may carry inhaler and self-administer in school.
☐ Yes ☐ No

_____ _____ _____

Physician Printed Name Address Phone

_____ _____

Signature of Physician Date