ONTARIO-MONTCLAIR SCHOOL DISTRICT

Health Services

Symptom Based – Asthma Action Plan

School Phone # _____
School Fax # _____

Student Name: _____ **Date of Birth:** _____ **School:** _____

Parent/Guardian: _____ **Home Phone:** _____ **Cellular:** _____

The following is to be completed by the PHYSICIAN (Items #1, 2, 3, and 4):

1. Medication(s) (taken at school AND home): **Please CHECK box if needed for use at school.**

A. "QUICK-RELIEF" Medication Name	**1.**	☐ For School *
	2.	☐ For School *
B. ROUTINE Medication Name (e.g. anti-inflammatory)	**1.**	☐ For School *
	2.	☐ For School *
	3.	☐ For School *
C. BEFORE PE, Exertion: Med Name	**1.**	☐ For School *
	2.	☐ For School *

2. For student on inhaled medication (all students must go to Health Office for oral medications)
- ☐ Assist student with inhaled medication in Health Office*
- ☐ May self-administer/self-carry inhaler medication.* Student demonstrates competence. (**Not** recommended in elementary school)

3. A spacer device (e.g. Aerochamber) use is advised for all students at school.

4. Check known triggers: ☐**tobacco** ☐**pesticides** ☐**animals** ☐**birds** ☐**cockroaches** ☐**cleansers** ☐**car exhaust** ☐**perfume** ☐**candles** ☐**mold** ☐**dust** ☐**cold air** ☐**exercise** ☐**smog** ☐**pollens** ☐**other** _____

5. Using the SYMPTOMS below, determine the appropriate ZONE and follow the action indicated:

Green Zone

Symptoms: Good breathing, no shortness of breath during day or night, no cough, no chest tightness, able to exercise and do usual activities

YELLOW ZONE	Action for school:
Symptoms: Starting to cough, wheeze, feel short of breath, chest tightness, waking at night due to asthma symptoms, or having some activity restrictions	1. Give "Quick – Relief" Medication(s)* 2. Notify Parent if symptoms are NOT relieved by medication after 15 - 20 min 3. If symptoms are NOT RELIEVED follow **School Emergency Plan** below 4. If symptoms are relieved, student may return to class **Notify Parent if "Quick – Relief" inhaler has been used more than two times this week (if not related to physical activity)*

RED ZONE	Action for school:
Symptoms: Cough, trouble walking or talking, chest/neck muscle retracting with breaths, hunched, blue color, wheezing or very diminished breathing sounds, very short of breath, moderate to severe activity restrictions, symptoms are the same or worse after 30 minutes in Yellow Zone	**1. Give "Quick – Relief" Medication(s)** **2. If symptoms are not improved within 15 to 20 minutes by student's "Quick – Relief" medication, or symptoms become worse, follow School Emergency Plan below**

SCHOOL EMERGENCY PLAN

1. ***REPEAT*** "Quick-Relief" medication(s) now
2. ***Call 911*** – Seek emergency care
3. Contact parent/guardian and school nurse
4. REPEAT "Quick-Relief" medication(s) in 20 minutes if help has not arrived and symptoms have not improved
5. Stay with student until paramedics arrive

Physician Name: _____ ***Physician Signature:*** _____ ***Date:*** _____

Address: _____ **Phone:** _____

City: _____ **Zip:** _____

I give permission for school staff to contact the physician for consultation and exchange of information as needed.

Signature of Parent or Guardian: _____ ***Date:*** _____ **Phone Number:** _____

* Medication Administration Form Required