

# Asthma Action Plan

Loudoun County Public Schools

[To be completed by Health Care Provider]

Name	Date of Birth	Teacher/Grade
Parent/Guardian	HOME	CELL
Health Care Provider Name	Emergency Phone Number(s)	
	Phone	Fax

Asthma Severity:    Intermittent    Mild Persistent    Moderate Persistent    Severe Persistent

Asthma Triggers:    Colds    Exercise    Animals    Dust    Smoke    Food    Weather    Other

## If Feeling Well (Green Zone)

You have all of these:

- Breathing is good
- No cough or wheeze
- Can work/play
- Sleeping all night

## Take Every Day: Long –Term Control Medications

MEDICINE:	HOW MUCH:	HOW OFTEN:	WHEN TO TAKE IT:

**5-15 minutes before exercise use this medicine**

--	--	--	--

## If Not Feeling Well (Yellow Zone)

You have any of these:

- Cough
- Wheeze
- Tight Chest
- Coughing at night

## Take Every Day Medications and ADD these Quick-Relief Medications

MEDICINE:	HOW MUCH:	HOW OFTEN:	WHEN TO TAKE IT:

Call doctor if these medicines are used more than two days a week.

## If Feeling Very Sick (Red Zone)

Your asthma is getting worse fast:

- Medicine is not helping
- Breathing is hard and fast
- Nose opens wide
- Cannot talk or walk well
- Ribs show when breathing in

## Take These Medicines and GET HELP from a Doctor NOW!

MEDICINE:	HOW MUCH:	HOW OFTEN:	WHEN TO TAKE IT:

**SEEK EMERGENCY CARE or CALL 911 NOW if: Lips are bluish, getting worse fast, hard to breathe, can't talk or cry because of hard breathing or child has passed out**

I have instructed this student in the proper use of his/her medications. It is my professional opinion that he/she should be allowed to carry and use this medication by him/herself.  YES  NO

In my professional opinion, this student should not carry his/her medication and it should be stored in the health office.  YES  NO

I give permission for school personnel to follow this plan, administer medication and care for my child and contact my health care provider if necessary. I assume full responsibility for providing the school with the prescribed medication.

Health Care Provider Signature/Date

Parent Signature/Date

Loudoun County Public Schools  
Asthma Individual Health Care Plan

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Teacher's Name \_\_\_\_\_ Grade \_\_\_\_\_

Symptoms of an asthma attack might include:

- |                    |                                     |
|--------------------|-------------------------------------|
| Coughing           | Gasping for air                     |
| Wheezing           | Color changes (pale or blue)        |
| Tightness in chest | Child states "difficulty breathing" |
| Other _____        |                                     |

If symptoms of an attack are present or \_\_\_\_\_ states that he/she feels an attack coming on:

- a. **DO NOT SEND STUDENT TO CLINIC ALONE.**
- b. If student cannot walk or talk in complete sentences, then the teacher should contact the clinic.
- c. Have student sit upright and sip water.
- d. Administer prescribed medication by inhaler or nebulizer.
- e. Reassure student and attempt to keep him/her calm and breathing slowly and deeply.
- f. Student should respond to treatment within 15-20 minutes.
- g. If no change, then contact the parent.
- h. **IF STUDENT'S BREATHING BECOMES SIGNIFICANTLY WORSE, CALL 911:**
  - Shoulders kept raised
  - Beaded perspiration
  - Blue lips, fingernails, or skin
  - Labored breathing
  - Pale
  - Skin between ribs or at base of neck collarbone retracts as student breathes

**Individual Considerations**

- Self pace for physical activities
- Inhaler before physical activities
- Physician approval for student to carry inhaler
- Restrictions ordered by physician: \_\_\_\_\_
- Other (Specify, i.e. recent hospitalization or ER visit): \_\_\_\_\_

**Bus**

Transportation will be alerted to student's asthma.

The student will carry an inhaler on the bus per physician order:  YES  NO

An inhaler can be found in:  Backpack  waist pack  other \_\_\_\_\_

**Additional accommodations should be discussed with school nurse or resource nurse.**

\_\_\_\_\_  
Parent Signature/Date

\_\_\_\_\_  
School Nurse or Resource Nurse/Date

Loudoun County Public Schools  
Parent/Student Agreement for Permission to Carry an Inhaler

*(Physician must also sign that student should carry an inhaler at school on the  
Asthma Action Plan)*

**Parent:**

- I give my consent for my child to carry and self-administer his/her inhaler.
- I understand that the school board or its employees cannot be held responsible for negative outcomes resulting from self-administration of the inhaled asthma medication.
- This permission to possess and self-administer asthma medication may be revoked by the principal if it is determined that your child is not safely and effectively self-administering the medication.
- A new Asthma Action Plan signed by the physician and Parent/Student Agreement for Permission to Carry an Inhaler must be submitted each school year.

---

*Parent/Guardian's Signature Required*

*Date*

**Student:**

- I have demonstrated the correct use of the inhaler to the school nurse/health clinic assistant.
- I agree never to share my inhaler with another person or use it in an unsafe manner.
- I agree that if there is no improvement after self-administering the medication, I will report to the school nurse/health clinic assistant or another appropriate adult if the nurse/health clinic assistant is not available or present.

---

*Student's Signature Required*

*Date*