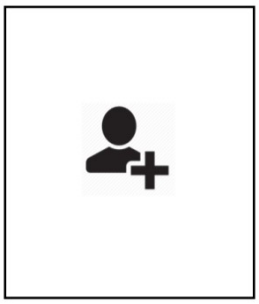
PULASKI COMMUNITY SCHOOL DISTRICT | STUDENT SERVICES OFFICE
Asthma Management Plan



Asthma Management Plan for School:

Child's name:	
Date of birth:	
School:	

Triggers that may exacerbate asthma for this child include:

☐ Weather (cold air)	☐ Illness	☐ Exercise	☐ Smoke	☐ Other _____
☐ Dog or cat	☐ Dust	☐ Mold	☐ Pollen	_____

MEDICAL PROVIDER COMPLETE FROM HERE ON DOWN

ASTHMA SEVERITY: ☐ Intermittent or ☐ Persistent ☐ Mild ☐ Moderate ☐ Severe

GREEN ZONE: PRETREATMENT STEPS FOR EXERCISE

☐ Give 2 puffs of rescue medication (name) _____ 15 minutes before activity

☐ PE Class ☐ exercise or sports activity ☐ recess ☐ no scheduled pre-treatment required

☐ Repeat in 4 hours if needed for additional or ongoing asthma

YELLOW ZONE: SICK–UNCONTROLLED ASTHMA

[If you see this]	[do this immediately]
► Difficulty breathing	► Stop physical activity
► Wheezing	► Give rescue medication (name): _____
► Frequent cough	☐ 1 puff ☐ 2 puffs ☐ via spacer ☐ other _____
► Complaints of chest tightness	► If no improvement in 10 -15 min. repeat use of medication
► Unable to tolerate regular activities	► Monitor child for worsening symptoms
but still can talk in complete sentences	► Stay with child and maintain sitting position
► Other: _____	► Call parents/guardians
_____	► Child may resume normal activities once feeling better

If there is **no rescue medication at school ***
Call parents/guardians to pick up child and/or bring inhaler/medication to school
Reassure them if student status transitions to an emergency situation, 911 will be called.

RED ZONE: EMERGENCY SITUATION

[If you see this]	[Do this immediately]
► Coughs constantly	► Give rescue medication (name): _____
► Struggles or gasps for breath	☐ 1 puff ☐ 2 puffs ☐ via spacer ☐ other _____
► Trouble talking (can only speak 3 to 5 words)	Repeat rescue medication if student not improving in 10-15 minutes
► Skin of chest and/or neck sucked in	☐ 1 puff ☐ 2 puffs ☐ via spacer ☐ other _____
► Lips or fingernails are gray or blue	► Call 911. Inform attendant that the reason for call is asthma
► Decreasing level of consciousness	► Call parents/guardians
If at school - call school E-Team for assistance	► Stay with child and remain calm
School personnel should <u>not</u> drive child to hospital	

Instructions for RESCUE INHALER USE: (Health provider please check appropriate box(es)

☐ Child understands the proper use of his/her asthma medications and can self-carry/use inhaler at school

☐ Child needs assistance or supervision to use his/her inhaler

☐ Child has life threatening allergy, Epipen is located: _____

► *Sign Here ...*

Parent/Guardian Authorization Signature	Date:	Physician/HCP Authorization Signature	Date:

Asthma Management Plan ... continued ...
Student Name

Additional Information or Instructions:

Contacts:

Doctor:	______________________	Phone:	( ) -
Parent/Guardian	______________________	Phone:	( ) -
Parent/Guardian	______________________	Phone:	( ) -
Other Emergency Contacts:			
Name/Relationship	______________________	Phone:	( ) -
Name/Relationship	______________________	Phone:	( ) -

Mail to:	Health Office, Pulaski Community School District, 2007 County Road U, Green Bay WI 54313.
Fax to:	(920) 865-6402

THIS SECTION TO BE REVIEWED & SIGNED BY PARENT OR GUARDIAN

I understand that medical information may be shared with school personnel or 911 responders for the safety of my child.

I understand that medication(s) may be administered by non-licensed school personnel who have received medication training.

I understand that permission to possess and self-administer a rescue inhaler may be revoked by the school nurse or principal if determined that my child is not able to safely self-administer medication.

I authorize the school nurse to exchange information verbally or in writing with the prescribing provider regarding this medication or the health condition for which it is prescribed.

My signature indicates that I have fully read and understand the information contained in this Asthma Management Plan.

My child has demonstrated to a licensed health care provider the skill necessary to use the prescribed rescue inhaler and any device necessary to self-administer medication. I hereby request and authorize my child to self-carry and/or self-administer their medication. ☐ Yes ☐ No

► *Sign Here ...*

Parent/Guardian Authorization Signature	**Date**

Notification of Change in my Child's Health Status

Please complete this portion and return to school if your child's health status has changed OR he/she does not require an Asthma Management Plan at school.

☐	My child no longer has Asthma Symptoms. He/she does not need a rescue inhaler at school.
☐	I will contact the school nurse if my child needs an Asthma Management Plan at school.
☐	Please contact me. I would like to schedule a meeting with the school nurse.

Your child's doctor will tell you what's best for your child. This information should not take the place of talking with your child's doctor