Bellevue Public Schools

Asthma Action Plan

B NRS 1034-3/23

Student information

Student's name _____ Date of Birth _____

School _____ Grade _____

Please complete this form with current information about your student's asthma, including actions to take should a problem arise. A new action plan is required each school year to be completed on or after May 1.

Contact information

Parent/Guardian 1 _____

Telephone Home _____ Work _____ Cell _____

Email address _____

Parent/Guardian 2 _____

Telephone Home _____ Work _____ Cell _____

Email address _____

Student's physician/health care provider _____

Address _____

Telephone _____ Fax _____

Peak Flow Meter Reading (If Peak Flow Meter Used)	**Treatment Plan**
Green Zone: _____ to _____ (peak flow #) **All clear.**	***Preventative*** **Daily Medications** Medicine: _____ How much: _____ When to take it: _____ _____ _____ Take _____ before exercise. (name of medicine)
Yellow Zone: _____ to _____ (peak flow #) **Caution.** **Take Action.**	***Quick Relief*** **For Mild/Moderate Symptoms** First, take this medicine. Medicine: _____ How much: _____ When to take it: _____ If no improvement in _____ minutes: _____ _____
Red Zone: _____ to _____ (peak flow #) **Medical Alert.**	***Alert*** **For Severe Symptoms** First, take this medicine. Medicine: _____ How much: _____ If the student does not get better or continues to get worse, call 911. Use Nebraska Schools' Emergency Response to Life Threatening Asthma or Systemic Allergic Reactions (Anaphylaxis) Protocol (at school, during school hours).

PLEASE COMPLETE BACK OF PAGE

Asthma Action Plan _____

Student's Last Name Student's First Name

1. What things "trigger" or cause your student's asthma symptoms? _____

   _____

   _____

   _____

2. Does exercising cause an asthma episode? ☐ Yes ☐ No

   If yes, should your student pre-treat with prescribed inhaler prior to exercise? ☐ Yes ☐ No

3. What are the usual symptoms your student experiences during an asthma episode, e.g. coughing, wheezing, etc?

   _____

   _____

   _____

4. Has your student required emergency room treatment for his/her asthma? ☐ Yes ☐ No

   If yes, please describe details and date of the last ER visit:_____

   _____

   _____

   _____

   _____

If medication is required at school, please provide the medication with the "Permission for Administration of Medication by School Personnel" form.

Note: If a student's parent/guardian and physician requests that the student self-manage his/her anaphylaxis condition at school, a self-management of anaphylaxis consent/release form must be completed and kept on file at the school. This is required by law.

I understand and agree this information will be reviewed by the school nurse and shared with school staff when appropriate. The school nurse may contact you or your student's physician/health care provider if additional information or clarification is needed. I authorize the school nurse or designated personnel to follow this asthma action plan and administer medications as detailed in this plan.

Physician signature_____Date_____

Parent/Guardian signature_____Date_____

Reviewed by school nurse_____Date_____

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