American Lung Association.

My Asthma **Action Plan**
For Home and School

Name: _____ DOB: ____ / ____ / _____

Severity Classification: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Asthma Triggers (list): _____

Peak Flow Meter Personal Best: _____

Green Zone: Doing Well

Symptoms: Breathing is good – No cough or wheeze – Can work and play – Sleeps well at night
Peak Flow Meter _____ (more than 80% of personal best)

Flu Vaccine—Date received: _____ **Next flu vaccine due:** _____ **COVID19 vaccine—Date received:** _____

Control Medicine(s)	Medicine	How much to take	When and how often to take it	Take at
	_____	_____	_____	☐ Home ☐ School
	_____	_____	_____	☐ Home ☐ School

Physical Activity ☐ Use Albuterol/Levalbuterol _____ puffs, 15 minutes before activity ☐ with all activity ☐ when you feel you need it

Yellow Zone: Caution

Symptoms: Some problems breathing – Cough, wheeze, or tight chest – Problems working or playing – Wake at night
Peak Flow Meter _____ to _____ (between 50% and 79% of personal best)

Quick-relief Medicine(s) ☐ Albuterol/Levalbuterol _____ puffs, every 20 minutes for up to 4 hours as needed
Control Medicine(s) ☐ Continue Green Zone medicines
☐ Add _____ ☐ Change to _____

You should feel better within 20-60 minutes of the quick-relief treatment. If you are getting worse or are in the Yellow Zone for more than 24 hours, THEN follow the instructions in the RED ZONE and call the doctor right away!

Red Zone: Get Help Now!

Symptoms: Lots of problems breathing – Cannot work or play – Getting worse instead of better – Medicine is not helping
Peak Flow Meter _____ (less than 50% of personal best)

Take Quick-relief Medicine NOW! ☐ Albuterol/Levalbuterol _____ puffs, _____ (how frequently)

Call 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

School Staff: Follow the Yellow and Red Zone instructions for the quick-relief medicines according to asthma symptoms.
The only control medicines to be administered in the school are those listed in the Green Zone with a check mark next to "Take at School".

☐ Both the Healthcare Provider and the Parent/Guardian feel that the child has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

Healthcare Provider
Name _____ Date _____ Phone (____) ____ - _____ Signature _____

Parent/Guardian
☐ I give permission for the medicines listed in the action plan to be administered in school by the nurse or other school staff as appropriate.
☐ I consent to communication between the prescribing health care provider or clinic, the school nurse, the school medical advisor and school-based health clinic providers necessary for asthma management and administration of this medicine.

Name _____ Date _____ Phone (____) ____ - _____ Signature _____

School Nurse
☐ The student has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

Name _____ Date _____ Phone (____) ____ - _____ Signature _____

Please send a signed copy back to the provider listed above.

American Lung Association.

How to Use a Metered-Dose Inhaler with a Valved Holding Chamber (Spacer)

Prime a brand-new inhaler: Before using it for the first time, if you have not used it for more than 7 days, or if it has been dropped.

1. Shake inhaler 10 seconds.

2. Take the cap off the inhaler and valved holding chamber. Make sure the mouthpiece and valved holding chamber are clean and there is nothing inside the mouthpieces.

3. Put inhaler into the chamber/spacer.

4. Breathe out away from the device.

5. Put chamber mouthpiece in mouth.

6. Press inhaler once and breathe in deep and steadily.

7. Hold your breath for 10 seconds, then breathe out slowly.

   If you need another puff of medicine, wait 1 minute and repeat steps 4-7.

8. Rinse with water and spit it out.

Proper inhalation technique is important when taking your asthma medicine(s) and monitoring your breathing. Make sure to bring all your medicines and devices to each visit with your primary care provider or pharmacist to check for correct use, or if you have trouble using them.

For more videos, handouts, tutorials and resources, visit Lung.org.

Scan the QR Code to access How-To Videos

You can also connect with a respiratory therapist for one-on-one, free support from the American Lung Association's Lung HelpLine at **1-800-LUNGUSA**.

PROCEDURE FOR ADMINISTRATION OF MEDICATION

Prior to the School Nurses administering any medication, the health office shall have on file a **Medication Authorization Form** for the involved student, prepared by the student's attending licensed prescriber in compliance with the Manasquan School District's procedures, and signed by the student's parent/guardian.

Whenever possible, the parent/guardian should plan for medication to be administered at home, before and/or after school hours. In situations when a student's health could be compromised by not receiving medication during school hours, school district procedures must be followed for administering all medications.

1. Medication is defined as prescription or non-prescription (over the counter) drugs, including vitamins and supplements.

2. Administration of any medication requires both a physician's written order and signed parental permission.

3. Prescription medication must be in a pharmacy or physician labeled container. Over the counter medication must in its original container, sealed and unopened with the manufacturers label, clearly marked with the student's name.

4. It is the parent's/guardian's responsibility to bring the medication to school.

5. All medications to be taken during school hours will be kept in the School Nurse's office. It is the responsibility of the student to report to the nurse's office at the proper time to receive his/her medication. Students are allowed to carry and self-administer asthma medication or may use an Epinephrine Auto-Injector for anaphylaxis only after the school is notified, the student's parent/guardian and physician have signed the Medication Authorization Form, and it has been approved by our School Physician.

6. The parent/guardian must assume responsibility for informing the school, in writing, of any change in the student's health or change in medication. A physician's order must accompany any medication change.

7. Medication must be picked up by a parent/guardian on or before the last day of school. Medication not picked up will be discarded. Medication authorization is to be renewed, if necessary, every school year.

8. The school district cannot dispense medication without the completed Medication Authorization Form received, reviewed, and approved. It is wise to have it completed and mailed to the Office of the School Nurse in August for the upcoming school year.

Please note: Any missing information on the Medication Authorization Form will render it incomplete and it will be returned to the parent/guardian for correction, which may delay implementation of a pharmacological treatment plan

MANASQUAN SCHOOL DISTRICT

MEDICATION AUTHORIZATION FORM

*For inhaler, if needed

Student's Name: _____ Date of Birth: _____

Grade: _____ Gender: _____ Home Address: _____

Parent/Guardian Name: _____ Contact #: _____

I (we) request authorization and consent to have the school nurse administer medication to my child, while in school, as prescribed by our private physician. The Manasquan BOE hereby informs the parents of the above child that the district shall not incur liability as a result of any injury from self-medication. I hereby sign that I have read the above statement and will hold the MBOE harmless against any injury or claims that arise as a result of my child's self-administration.

Signed _____ Date_____

TO BE FILLED OUT BY PHYSICIAN

Diagnosis: _____Name of Medication: _____

Dosage, Form & Time: _____

If given prn, describe indications: _____ When can it be repeated? _____

Significant side effects include: _____

Is this medication for a life-threatening illness? _____ Is the child authorized to self- administer? ____

Has the child been trained by the healthcare provider? _____

Length of time this order is valid (may NOT exceed school year): _____

Physician's Signature: _____ Date: _____

Physician's Stamp:

APPROVAL OF SCHOOL PHYSICIAN

I have reviewed the above request and authorize the school nurse to administer the prescribed medication as ordered during school hours.

School Physician's Signature _____ Date: _____