Lee County School District
Asthma Action Plan

Students Name: _____ Student's DOB: _____
Emergency Contact: _____ Phone Number:_____
Health Care Provider: _____ Phone number: _____

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

Triggers: ☐ Colds ☐ Exercise ☐ Animals ☐ Dust ☐ Food ☐ Smoke ☐ Weather ☐ Air Pollution
☐ Other _____ Home Medications _____

Green Zone - Doing Well

Symptoms : *Breathing is good *No cough or wheeze *Can work and play *Sleeps all night

Medication _____ # of Puffs ☐ Minutes prior to exercise ☐ With Aero-chamber/Spacer ☐

Yellow Zone - Getting Worse

Symptoms: *Some difficulty breathing *Cough *Wheeze *Chest tightening *Problems working or playing *Awake at night

Medication _____ # of Puffs ☐ Frequency _____ With Aero-chamber/Spacer ☐

May repeat every ☐ minutes times ☐ . If symptoms not improved notify parent/guardian and school nurse

Nebulizer _____ Dose _____ Frequency _____

All equipment needed to perform nebulizer treatment will be provided and maintained in good working order by parent/guardian. School personnel will assume no responsibility for the maintenance or delivery of the necessary equipment. Nebulizer treatment/procedure may be administered by unlicensed personnel trained by the school nurse.

Red Zone - Medical Alert

Symptoms: Difficulty breathing *Cannot work or play *Getting worse instead of better *Medicine is not helping

Call EMS immediately if the following danger signs are present: Remains in the red zone after 15 minutes, trouble walking/ talking due to shortness of breath, lips and/or fingernails are blue.

☐ **If pulse oximeter is available call EMS if O2 saturation is less than** ☐

****Physician's Signature** for above orders:_____ Date: _____

Authorization to carry and self-administer medication - Must be completed by the health care provide

Student my carry and self-administer rescue inhaler: ☐ Yes ☐ No If yes, please complete the following:

☐ Student instructed on and verbalized understanding of the name. purpose, dose of medication.
☐ Student instructed on disease process of asthma and verbalized understanding of when to take medication.
☐ Student instructed on and verbalized understanding of his/her responsibility in carrying medication(s) and agrees not to share w/other Students
☐ Demonstrated correct use/administration of medication.

I, _____ understand that I am responsible and accountable for using and carrying the above medication as prescribed. I also understand that if there is irresponsible behavior or a safety risk the privilege of carrying the above medication will be rescinded.

Student's Signature:_____Date:_____

****Physician's Signature** for carry and self administration:_____ Date: _____

Florida Statute 1006.062 requires written parental consent for a student to take medication during the school day. Please refer to "Guidelines for Administration of Medication" on the following page.I agree with the above prescribed medication regimen, and authorize the personnel of The School District of Lee County, Florida to administer medication to my child/student. It is understood that this medication will be administered, if needed, on field trips. I also authorize the school nurse to contact the prescribing licensed health care provider or his/her designee to exchange information concerning the purpose, dosage, and effects of this medication.

Parent/Guardian's Signature:_____Date:_____

School Nurse's Signature: _____ Date: _____