Corvian Asthma Action Plan

Name: _____ **DOB:**_____

Doctor: _____ **Date:**_____

Phone for Doctor or Clinic: _____

Predicted/Personal Best Peak Flow Reading:_____

Asthma Triggers

Try to stay away from or control these things:

□ Exercise	□ Smoke, strong odors or spray
□ Mold	□ Colds/Respiratory infections
□ Chalk dust/dust	□ Carpet
□ Pollen	□ Change in temperature
□ Animals	□ Dust mites
□ Tobacco smoke	□ Cockroaches
□ Food _____	□ Other _____

1. Green – Go

- Breathing is good.
- No cough or wheeze.
- Can work and play.

Or Peak Flow _____ to _____ (80-100%)

Use these controller medicines *every day* to keep you in the green zone:

Medicine:	How much to take:	When to take it:	
			□ Home □ School

5-15 minutes before very active exercise, use □ Albuterol _____ puffs.

2. Yellow – Caution

Coughing

Wheezing

Tight Chest

Wakes up at night

Or Peak Flow _____ to _____ (50-80%)

***Keep* using controller green zone medicines everyday.**

***Add* these medicines to keep an asthma attack from getting bad:**

Medicine	How much to take	When to take it
Albuterol or _____	□ 2 puffs by inhaler □ 4 puffs by inhaler □ with spacer, if available □ by nebulizer	□ May repeat every 20 min up to 3 doses in first hour, if needed

If symptoms ***DO NOT*** improve after first hour of treatment, then go to ***red zone.***

If symptoms ***DO*** improve after first hour of treatment, then continue:

Albuterol or _____	□ 2 puffs by inhaler □ 4 puffs by inhaler □ with spacer, if available □ by nebulizer	□ Every 4 - 8 hours for _____ days

_____, _____times a day for _____days □ Home □ School
(oral corticosteroid) *(how much)*

Call your doctor if still having some symptoms for more than 24 hours!

3. Red – Stop – Danger

- Medicine is not helping.
- Breathing is hard and fast.
- Nose opens wide.
- Can't walk.
- Ribs show.
- Can't talk well.

Or Peak Flow _____ (Less than 50%)

Call* your doctor and/or parent/guardian *NOW!
***Take these medicines* until you talk with a doctor or parent/guardian:**

Medicine:	How much to take:	When to take it:
Albuterol or _____	□ 2 puffs by inhaler □ 4 puffs by inhaler □ with spacer, if available □ by nebulizer	□ May repeat every 20 minutes until you get help

_____, _____times a day for _____days □ Home □ School
(oral corticosteroid) *(how much)*

Call 911 for severe symptoms, if symptoms don't improve, or you can't reach your doctor and/or parent/guardian.

Physician Signature _____ **Date**_____ **Phone**_____

WHITE – PATIENT YELLOW – CHART PINK – SCHOOL

Provided by Community Care of N.C., N.C. Asthma Program, and Asthma Alliance of N.C. 10/08

4041 Johnston Oehler Rd
Charlotte, NC 28269
Phone 704-717-7550

REQUEST FOR MEDICATION ADMINISTRATION

(each medication must be listed on a separate form)

Valid for school Year 20____ to 20____

Student Name:_____ **Date of Birth:**_____ **Current School Grade:**_____

Medication:_____ **Dosage:**_____ **Route:**_____

Time(s) medication is to be given: A.M. _____ **P.M.** _____ **PRN:** _____

Side effects, Interactions, Etc: _____

Prescribing Health Care Provider Signature:	**Date:**
Health Care Provider Name:	**Phone #:**

Parent/Guardian Agreement: I give my permission for my child (named above) to receive medication during school hours. I agree to send the medication in its original container. As the parent/guardian of this child, I assume the responsibility of any adverse reactions this medicine may cause for my child and I, hereby, release the Board of Directors, School Administration and employees from all liability. I understand that school staff will distribute medication based on the instructions on the original container. This will not be done by a nurse or under the supervision of a nurse.

Parent/Guardian Signature:	**Date:**
Parent/Guardian Name:	**Phone #:**

SELF-MEDICATION STUDENT AGREEMENT *(only applicable for 6th grade and above)*

- Non emergent medications are kept in the office.
- Emergent Medications that can be carried by student *(only if this form is completed and on file)*:
  - **Asthma/Allergic Reactions: ____MDI (Metered Dose inhaler) ____MDI with spacer**
  - **Diabetes: _____Insulin ____ Glucose**
  - **Anaphylaxis: ____Epinephrine**

Health Care Provider Agreement: I agree that this student is authorized to medicate himself/herself, has been instructed and has demonstrated the skill level necessary to use the prescribed medication/device. In order to keep this child in optimum health and to aid school performance it is necessary that this medication be self-administered during school hours. The student's parent/guardian has been informed and is in full agreement.

Healthcare Provider Signature:
(Signature also required at top of form)

Parent/Guardian Agreement: I agree that my child (named above) is knowledgeable of his/her treatment and is capable of self-administering this medication. I understand that the school and its employees are not liable for an injury arising from a student's possession and self-administration of medication. If applicable, I understand that I should provide the school with backup medication that shall be kept in the office so my child has immediate access to their medication in the event my child forgets or loses their supply. I understand that all non-emergent medications will be kept in the office and it is my child's responsibility to go to the office when the medications are due or needed.

Parent/Guardian Signature:
(Signature also required at top of form)

Self-Medicating Student Agreement: I agree and understand how to take my medicine as prescribed by my doctor. I will not share my medicine with anyone. I will keep my emergency medicine in a safe and secure place away from other students. My non emergent medications will be kept in the office and I will go to the office to take them at the scheduled time or as needed. I understand that if I do not follow the above rules, I may lose my privilege to give myself my own medicine while at school.

Student Signature:	**Date:**

To comply with requirements stated in G.S. 115C –375.2, the following must be developed/signed by the student's health care provider and accompany this form: • ***Emergency Action Plan*** *(for students needing an Epi-Pen, Asthma, or Seizure medication;)* • ***Diabetes Care Plan*** *(for students with diabetes).*

******Turn all forms into the front office.******

Nurse Signature_____ **Print** _____