Edmond Public Schools
ASTHMA ACTION PLAN

School Year:

School:	**Teacher:**	**Grade:**
Student Name		**Date of Birth**
Parent/Guardian	**Parent/Guardian Phone**	**Parent/Guardian Email**
Emergency Contact		**Emergency Contact Phone**

Green Zone: Go!

You have **ALL** of these:

- Breathing is easy
- No cough or wheeze
- Can work and play
- Can sleep at night

Take these CONTROL (PREVENTION) Medicines at Home Every Day

☐ No control medicines required

☐ Advair ☐ Flovent ☐ Pulmicort ☐ Symbicort ☐ Singulair (Montlukast)

☐ Other: _____

For asthma with exercise, ADD: ☐ Albuterol ☐ Other_____ ☐ Daily ☐ As Needed
MDI _____ puffs _____ minutes before exercise at school ☐ **PE class** ☐ **Recess** ☐ **Sports**

Yellow Zone: Caution!

You have **ANY** of these:

- Cough or mild wheeze
- First sign of cold
- Tight chest
- Problems sleeping, working, or playing

Continue CONTROL Medicines and ADD RESCUE Medicines

☐ Albuterol ☐ Levalbuterol (Xopenex) ☐ Ipratropium (Atrovent)

MDI _____ puffs every _____ hours as needed

☐ Albuterol 2.5mg/3ml ☐ Levalbuterol (Xopenex) _____ ☐ Ipratropium (Atrovent) 2.5 mg/3 ml

One nebulizer treatment every _____ hours as needed

☐ Other: _____

Red Zone: DANGER!

You have **ANY** of these:

- Can't talk, eat or walk well
- Medicine is not helping
- Breathing hard and fast
- Blue lips and fingernails
- Tired or lethargic
- Ribs show

Continue CONTROL & RESCUE Medicines and GET HELP!

☐ Albuterol ☐ Levalbuterol (Xopenex) ☐ Ipratropium (Atrovent)

MDI _____ puffs **every 15 minutes**, for **THREE** treatments

☐ Albuterol 2.5mg/3ml ☐ Levalbuterol (Xopenex) _____ ☐ Ipratropium (Atrovent) 2.5 mg/3 ml

One nebulizer treatment **every 15 minutes**, for **THREE** treatments

☐ Other: _____

CALL 911

*****A completed Authorization for Medication form must be completed and attached for medication at school*****

Physician/Licensed Health Provider _____ Date_____
Signature Phone _____

I give permission for school personnel to follow this plan, administer medication and care for my child following EPS Policy and contact my provider if necessary**. I understand this Asthma Action Plan must match the Authorization for Medication form completed by my Licensed Healthcare Provider.** I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I understand this plan is valid for this school year only and must be renewed at the beginning of each school year.

☐ I understand and acknowledge the above statement. ☐ I do not understand and acknowledge the above statement.
Call 405-340-2215 if additional information is needed.

Parent/Guardian Signature_____ Date_____

Edmond Public Schools Fax # _____

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION

One Medication per Form

Authorization and request for the administration of medication at school for prescription and/or non-prescription medication.

Student_____ **Birthdate** _____ **Grade**_____ **School Year** _____

School_____ **Teacher**_____ **Date received** _____

- **TO BE COMPLETED BY THE LICENSED PHYSICIAN OR PRESCRIBER**

1. **Reason for medication** _____
2. **Name of medication** _____
3. **Dosage** _____
4. **Time to be administered** _____
5. **Duration (week, month, indefinite, etc.)** _____
6. **Side Effects:** ☐ **None Expected** ☐ **Specify** _____
   _____
7. **Form of medication/treatment: Tablet**____ **Liquid**____ **Inhaler**____ **Injection**____ **Nebulizer**____ **Other**_____
8. **Special storage requirements: None** _____ **Refrigerate** _____

_____ _____ _____

Licensed Prescriber Signature **Name (please print)** **Date**

_____ _____ _____

Address **Phone** **Fax**

TO BE COMPLETED BY THE PARENT/GUARDIAN:

I hereby request and give my permission for the above named school to administer the medication prescribed on this form. Prescription medication must have the pharmacy label attached and must match the written prescriber order. "Over the counter medication" must be in the original, unopened container. All medication must be brought to school by an adult. **Substances not approved by the FDA will not be stored nor administered by school personnel.** I further understand that I will be responsible for picking up any remaining medication at the end of the school year; medication will NOT be sent home with students. Any medication remaining after the school year has ended will be discarded utilizing proper procedure. The school nurse may consult with the prescriber regarding this prescription. Changes to the time and/or dosage of the medication require written authorization from the licensed prescriber and parent/guardian.

☐ **I understand and acknowledge the above statement.** ☐ **I do not understand and acknowledge the above statement.**
Call 405-340-2215 to request to speak with a school nurse if additional information is needed.

_____ _____

Parent/Guardian Signature **Date**

COMPLETE FOR SELF-ADMINISTRATION AND/OR SELF CARRY OF

ASTHMA, ANAPHYLAXIS, REPLACEMENT PANCREATIC ENZYME AND DIABETES MEDICATION ONLY

TO BE COMPLETED BY THE LICENSED PHYSICIAN/PRESCRIBER:

- **This student has been instructed and is capable and responsible to self-administer this medication: Yes** ____ **No** ____
- **This student may carry this medication on their person: Yes**____ **No**____

_____ _____

Licensed Prescriber Signature (Required) **Date**

- **TO BE COMPLETED BY THE PARENT/GUARDIAN:**

Authorization for Self-Administration and/or Self-Carry of Medication

THE SCHOOL DISTRICT SHALL INCUR NO LIABILITY AS A RESULT OF ANY INJURY ARISING FROM THE SELF-ADMINISTRATION AND/OR SELF-CARRY OF MEDICATION BY MY STUDENT/CHILD. PURSUANT TO OKLAHOMA LAW, I UNDERSTAND I AM *REQUIRED TO PROVIDE THE SCHOOL WITH AN EMERGENCY SUPPLY OF THE MEDICATION(S).*

_____ _____

Parent/Guardian Signature **Date**

I will not knowingly share my medication with another student.

_____ _____

Student Signature **Date**