American Lung Association.

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

Scan the QR Code to access How-To Videos

Name: _____ School: _____ DOB: ____ / ____ / _____

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

Asthma Triggers (list): _____

Date Completed: ____ / ____ / _____

Green Zone: Doing Well

Symptoms: Breathing is good – No cough or wheeze – Can work and play – Sleep well at night

	Medicine	How much to take	When and how often to take it	Take at
Control Medicine(s)				☐ Home ☐ School
Quick Relief Medicine(s)				☐ Home ☐ School
SMART/ MART	☐ ICS/Formoterol _____	___ puff(s) with spacer	_____	
	(daily max dose 12 puffs for ages 12+ yrs & 8 puffs for ages 4-11 yrs)			
Exercise Induced	☐ Use quick-relief medicine 10 minutes before physical activity as instructed			

Yellow Zone: Caution

Symptoms: Some problems breathing – Cough, wheeze, or tight chest – Problems working or playing – Wake at night

	Medicine	How much to take	When and how often to take it
Quick-relief Medicine(s)	☐ _____	_____	_____ *every 20 minutes for up to 1 hour OR Nebulizer (use once)*
Control Medicine(s)	☐ Continue Green Zone medicines		
SMART as quick reliever	☐ ICS/Formoterol _____	___ puff(s) with spacer	_____
	(daily max dose 12 puffs for ages 12+ yrs & 8 puffs for ages 4-11 yrs)		
Other	☐ _____	_____	_____

You should feel better within 20–60 minutes of the quick-relief treatment. If you are getting worse THEN follow the instructions in the RED ZONE and call your doctor or 911 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 – I feel very sick

Take Quick-relief Medicine NOW!

	Medicine	How much to take	When and how often to take it
	☐ _____	___ (puffs)	_____
SMART as quick reliever	☐ ICS/Formoterol _____	___ puff(s) with spacer	_____
Other	☐ _____	_____	_____

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

Parent/Guardian

☐ I give permission for the medicines listed in the action plan to be administered in school by the nurse or designated trained staff.

☐ I consent to communication between the prescribing health care provider or clinic, the school nurse, the school medical advisor or school-based health clinic providers necessary for asthma management and administration of this medicine.

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

Healthcare Provider Student is able to self carry/self medicate YES NO

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

Please provide a signed copy to the parent, school nurse and healthcare provider.

Waverly Community Schools Medication Administration Authorization Form

Michigan State Law requires that school staff administering medications must have written orders from the physician/licensed prescriber and written authorization from the parent/guardian**.**
Parents are urged to give medication at home on a schedule outside of school hours, if possible. If it is necessary that medication be provided during school hours, these regulations must be followed:

- All prescription medications must have a written order from a physician or other licensed prescriber and must be renewed every year or with any changes. Any medication that is a controlled substance must be renewed every 30 days or with any changes.
- All medication must be brought to school in the original pharmacy or OTC container labeled with the name of the student, medication, strength, dosage, route, and time(s) to be given. The parent/guardian is expected to deliver the medication to the school. Students are not allowed to bring their own medication to school.
- Medications and related equipment/supplies, as ordered, must be provided to the school by parent/guardian as needed.
- A separate authorization form must be completed for each medication that will be administered throughout the school day.

STUDENT'S NAME: _____ DATE OF BIRTH: _____

SCHOOL:_____

TO BE COMPLETED BY THE PHYSICIAN:

Medication Name	Dosage	Route	Frequency and Time

Form of Medication: ☐ Tablet/Capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Other:	
Diagnosis:	
Special instructions/storage requirements:	
Restrictions and/or important side effects:	
Is student able to self-carry this medication? ☐ Yes ☐ No	
Order start date:	**Order end date:**
(If no end date is indicated, medication orders will expire at the end of the current school year).	
Prescriber signature:	**Date:**
Printed Name:	**NPI#:**
Address:	
Phone:	**Fax:**

TO BE COMPLETED BY THE PARENT/GUARDIAN:

I hereby give permission for school personnel to exchange this information as necessary, administer medication, and provide care for my child, and to contact the child's physician when deemed necessary. I assume full responsibility for providing the school with all prescribed medications as outlined above and any required medical equipment or devices.

I understand and agree that, pursuant to Public Act 157 of 1971 (MCL 380.1178), when school personnel administer medication to my child in accordance with this authorization, I shall not hold the school district, its employees, or agents liable in any criminal action or for civil damages resulting from the administration of such medication, except as provided by law.

All medications must be picked up by a parent or legal guardian within one (1) week following the student's last day of classes. Any medication not collected within this timeframe will be disposed of in accordance with applicable laws and school district policy.

Signature:	Relationship:	Date:

Please return completed form to the school office or to the District Nurse

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