<b>Asthma Action Plan</b>			Date Completed
Name		Date of Birth	Grade/Teacher
Health Care Provider		Health Care Provider's Office Phone	Medical Record Number
Parent/Guardian		Phone	Alternate Phone
Parent/Guardian/Alternate Emergency Contact		Phone	Alternate Phone
DIAGNOSIS OF ASTHMA SEVERITY  Intermittent Persistent (	Mild ○ Moderate ○ Severe ]	ASTHMA TRIGGERS (Things That M Smoke Colds Exercise Weather Odors Pollen	se 🗌 Animals 🔲 Dust 🔲 Food
GREEN ZONE: GO!	Take These DAILY CONTRO	LLER MEDICINES (PREVENTION) Me	dicines <b>EVERY DAY</b>
You have ALL of these:  Breathing is easy  No cough or wheeze  Can work and play  Can sleep all night	Take puff(s) or  For asthma with exercise, puffs with space	s):tablet(s) daily.	
YELLOW ZONE: CAUTION!	Continue DAILY CONTROLL	ER MEDICINES and ADD QUICK-REL	IEF Medicines
You have ANY of these: Cough or mild wheeze Tight chest Shortness of breath Problems sleeping, working, or playing	Takepuffs every  Take a  Other  If quick-relief medicine does not grave to be a controlled to be a cont	f ordered and add this quick-relief medicine hours, if needed. Always use a sp nebulizer tree of HELP within minutes, take it againore than times in hours, or the than 24 HOURS, CALL HEALTH CAR	inhaler mcg pacer, some children may need a mask. nebulizer mg / ml atment every hours, if needed. in and CALL your Health Care Provider CALL your Health Care Provider
RED ZONE: EMERGENCY!	Continue DAILY CONTROLL	ER MEDICINES and QUICK-RELIEF N	Medicines and GET HELP!
You have ANY of these:  • Very short of breath  • Medicine is not helping  • Breathing is fast and hard  • Nose wide open, ribs showing, can't talk well  • Lips or fingernails are grey or bluish	Take a  Other  CALL HEALTH CARE PROVIDE	hours, <i>if needed</i> . Always use a sp nebulizer tres R AGAIN WHILE GIVING QUICK-RELIEF N AN AMBULANCE OR GO DIRECTLY TO TH	nebulizer mg / ml atment every hours, if needed.  TEDICINE. If health care provider cannot
Signature Parent/Guardian Permission: I give cons 減分之外的次数多数的知识。	est this plan to be followed as written.  ent for the school nurse to give the me  KNOKENERWIN KNOKENERWIN	This plan is valid for the school yearDate  dications listed on this plan of MANNEY XX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
effectively and may carry and use this me Signature Parent/Guardian Independent Carry and may carry and use this medication indepe	and Use Permission: I attest that this dication independently at school with I Use Permission (If Ordered by Provid	student has demonstrated to me that they ca no supervision by school personnel.  Date ler Above): I agree my child can self-administ by school personnel.	er this rescue medication effectively and
Signature		Date	

## AUTHORIZATION FOR ADMINISTRATION OF ASTHMA PRESCRIPTION MEDICATION

## RECOMMENDATIONS ARE EFFECTIVE FOR THE CURRENT SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY

Student Name:		Grade: _	
Emergency Contacts: (Name	and Phone#'s):		
I request that my child pursuant to N.J.S.A. 18A:40-prescribed on this form for th storing and self-administration no liability as a result of any prescribed on this form. I indicate the second self-administration of the self-administration of the second self-administration o	12.3 and 12.4. I give permission e current school year. I consider to the medication. I understand to condition or injury arising from the	f-administer in school, his asthut for my child to self-administer his him/her to be responsible and captat the school district, agents and eself-administration by the stude chool District, its agents and emp	s/her medication, as apable of transporting, d its employees shall incur ent of the medication
taking the medication describ medication to students in sch of the medication is mine, an at another location at the time employees shall incur no liab administration of the medicat	ped below at school by the School pursuant to N.J.A.C:.6A:16- d I am fully aware that the duties e that the medication is needed. oility as a result of any condition tion prescribed on this form. I inc	ima medication. I request that roll Nurse or other individuals auth 2.3. I understand the ultimate resist of the school nurse and others in I understand that the school distror injury arising from the administration of this medical contents of administration of this medical numbers.	norized to administer sponsibility for administration may require their presence rict, agents and its tration or lack of chool District, its agents and
Parent/Guardian Signature	Telephone	Date	
II. Healthcare Provider	Order:		
Name of medication:			
Dosage:	Route:	Frequency;	
For Student Self Administration:This student has been insThis student understandsThis student is <b>not</b> approve	tructed in and is capable of proper of the purpose, appropriate method an	method of self-administration of the m nd frequency of use of the medication	nedication prescribed above. n prescribed above.
Physician's Name	Signature	Date	•
Office Stamp:			

This form must be individually completed for all medications.

Medications are to be brought to school by the parent in the **original container**, labeled appropriately by the pharmacy. All medications **will be kept** in a locked storage area.