School Respiratory Action Plan Date: _____

Place student picture in corner

Student's Name:	Date of Birth:
School:	Grade Level:
Physician:	Office Phone:

Medical Information	Respiratory Diagnosis:	□ Asthma	□ Reactive Airway Disease
		□ Vocal Cord Dysfunction	
	□ Other (Please Specify)		

Long-Term Control Medications:	
Medication:	Directions (*How Much to Take and How Often to Take it*):
Quick Relief Medication(s):	
Medication:	Directions (*How Much to Take and How Often to Take it*):

□ I Use A Peak Flow Meter
My Green Zone (80%-100%) is _____ to _____
My Yellow Zone (50%-80%) is _____ to _____
My Red Zone (<50%) is less than _____

Respiratory Triggers:	
□ Viral Infections	□ Exercise
□ Irritants	□ Emotions
□ Allergens (Please Specify):	

Treatment Plan		
The nurse may administer rescue medication for symptoms including shortness of breath, chest tightness, difficulty breathing, wheezing, or a Yellow or Red Zone peak flow. In addition, I request that he/she administer rescue medication:		
□ before recess	□ before gym class	□ before sports practice or games

Step 1	Rest and rescue medication
Step 2	Second dose of rescue medication, and add additional medication(s):
Step 3	Call parent or physician, if a parent is not available

□ I have instructed _____ {student} in the proper way to use his/her asthma medications. It is my professional opinion that _____ **should** be allowed to carry and use the prescribed medication while at school or school related events.

Physician Signature: _____ Date: _____

(*Physician signature required if student carrying inhaler*)

By completing and returning this School Respiratory Action Plan, I hereby authorize the nurse, coaches, and/or other school staff to administer the medication(s) that I have provided and give school staff permission to communicate with my child's physician(s).

Parent/Guardian Signature:	Date