OCONOMOWOC AREA SCHOOL DISTRICT

EMPOWERING A COMMUNITY OF LEARNERS AND LEADERS

Valid for School Year:
20_____-20_____
Grade: _____
School: _____

Asthma Health Care Plan

District Nurse Phone: 262-560-2104
District Nurse Fax: 262-560-2106

Student Name:_____Date of Birth:_____

Practitioner Name_____ Practitioner Phone_____ Practitioner Fax_____

Severity Classification ☐ Intermittent (with illness) ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent ☐ No longer a concern
Asthma Triggers (List) _____

GREEN ZONE - DOING WELL! Breathing is good. No cough or wheeze. Can work and play. Sleeps well at night.

Control Medicine(s)	Medicine	Number of Puffs	How Often/Frequency	Take at:
	_____	_____	_____	☐Home ☐ School
	Medicine	Number of Puffs	How Often/Frequency	Take at:
	_____	_____	_____	☐Home ☐ School

Physical Activity ☐Use albuterol/levalbuterol ____puffs, 15 minutes prior to activity ☐with all activity ☐when he/she feels it is needed

YELLOW ZONE – CAUTION! Cough. Wheeze. Tight Chest. Wake at night coughing.

Quick-relief Medicine(s) ☐ Albuterol/levalbuterol ____puffs, every 4 hours as needed OR 1 nebulizer treatment of_____
☐ Repeat after 20 minutes if needed (for a maximum of 2 treatments)
☐ Schedule up to 2 times per school day per parent request, at least_____hours between treatments
Control Medicine(s) ☐Continue Green Zone medicines

If you are in the **YELLOW ZONE** more than 24 hours or are getting worse, follow **RED ZONE** and call your doctor right away!

RED ZONE – MEDICINE IS NOT WORKING. GET HELP NOW!
Breathing is hard. Nostrils are open. Ribs are showing. Lips/fingernails gray or pale.

Take Quick-relief Medicine NOW ☐ Albuterol/levalbuterol _____puffs, every _____minutes/hours, for _____treatments as needed

Ca11 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

☐This Asthma care plan provides authorization for the administration of medicine described at school
☐This child has the knowledge and skills to self-carry and self-administer medicine at school with the approval of the school nurse

Practitioner Signature_____ Date:_____

- I hereby give permission to OASD's trained staff to give the medication(s) to my child according to the directions stated above and further authorize them to contact the child's practitioner with any concerns regarding medication administration. I agree to hold the Oconomowoc Area School District, its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.
- I allow the named practitioner (office) to send by electronic transmission this form to the Oconomowoc Area School District for the purpose of continuing health care at school.
- I give the school staff, including the district designated health care professional, permission to call me with any concerns regarding medication administration.

******Please supply the school with the needed medication(s) on or prior to the first day of school******

How should medicine(s) be returned the last week of school: ☐ Sent home with student ☐ Parent/Guardian pick-up

Parent Signature_____ Date:_____