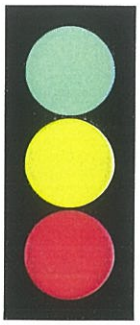
Massachusetts Asthma Action Plan

Name:		Date:
Birth Date:	Doctor/Nurse Name	Doctor/Nurse Phone #
Patient Goal:		Parent/Guardian Name & Phone
Important! Avoid things that make your asthma worse:		



The colors of a traffic light will help You use your asthma medicine.

Green means **Go Zone!** Use controller medicine.

Yellow means **Caution Zone!** Add quick-relief medicine.

Red means **Danger Zone!** Get help from a doctor.

Personal Best Peak Flow: _____

GO – You're Doing Well! ➡ Use these daily controller medicines:

You have *all* of these:
- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can go to school and play

Peak flow from _____ to _____

MEDICINE/ROUTE	HOW MUCH	HOW OFTEN/ WHEN

CAUTION – Slow Down! ➡ Continue with green zone medicine and add:

You have *any* of these:
- First signs of a cold
- Cough
- Mild wheeze
- Tight Chest
- Coughing, wheezing, or trouble breathing at night

Peak flow from _____ to _____

MEDICINE/ROUTE	HOW MUCH	HOW OFTEN/ WHEN

CALL YOUR DOCTOR/ NURSE: _____

DANGER – Get Help! ➡ Take these medicines and call your doctor now.

Your asthma is getting worse fast:
- Medicine is not helping
- Breathing is hard and fast
- Nose opens wide
- Ribs show
- Can't talk well

Peak flow from _____ to _____

MEDICINE/ROUTE	HOW MUCH	HOW OFTEN/ WHEN

GET HELP FROM A DOCTOR NOW! Do not be afraid of causing a fuss. Your doctor will want to see you right away. It's important! If you cannot contact your doctor, go directly to the emergency room and bring this form with you. DO NOT WAIT.

Make an appointment with your doctor / nurse within two days of an ER visit or hospitalization.

Doctor /NP/PA Signature: _____ Date: _____

I give permission to the school nurse, my child's doctor/NP/PA or _____ to share information about my child's asthma

Parent/Guardian Signature: _____ Date: _____

****SEE BACK OF SCHOOL COPY FOR STUDENT MEDICATION ADMINISTRATION AUTHORIZATION****

ADAPTED FROM NIH PUBLICATION (7/20/01)

IMPORTANT INSTRUCTIONS: SEPARATE THIS PAGE BEFORE WRITING

Consent for administration of medication in school:

I consent to have the school nurse or school personnel designated by the school nurse administer the medication as prescribed on the reverse side of page.
Parent/Guardian Signature_____ DATE_____

Authorization for student self-administration of medication in school:

I have instructed this student in the proper way to use his/her medications. Medications administered must be consistent with school policy and a medication plan must be developed with the school nurse in accordance with the Massachusetts Regulations Governing the Administration of Prescription Medications in Public and Private Schools (105 CMR 210.000), as printed below. Translated copies of the regulation can be obtained from the Massachusetts Department of Public Health 250 Washington Street, Boston, MA 02118. It is my professional opinion that this student may self-administer the medication and may be allowed to carry and use his/her medications by him/herself.

COMMENTS/ SPECIAL INSTRUCTIONS:

SIGNATURES **DATE**

Student's Doctor/Nurse _____ _____

Parent/Guardian _____ _____

Medication administration plan completed_____ _____

School Nurse's approval _____ _____
SIGNATURE

Listed below are regulations governing the self – administration of Prescription medication 105 CMR 210.006

(A) Consistent with school policy, students may self-administer prescription medication provided that certain conditions are met. For the purposes of 105 CMR 2100.000, "self administration" shall mean that the student is able to consume or apply prescription medication in the manner directed by the licensed prescriber, without additional assistance or direction.
(B) The school nurse may permit self medication of prescription medication by a student provided that the following requirements are met:
(1) the student, school nurse and parent/guardian, where appropriate, enter into an agreement which specifies the conditions under which prescription medication may be self administered;
(2) the school nurse, as appropriate, develops a medication administration plan (105 CMR 210.005 (E) which contains only those elements necessary to ensure safe self administration of prescription medication;
(3) the school nurse evaluates the student's health status and abilities and deems self-administration safe and appropriate. As necessary, the school nurse shall observe initial self-administration of prescription medication;
(4) the school nurse is reasonably assured that the student is able to identify the appropriate prescription medication, knows the frequency and time of day for which the prescription medication is ordered, and follows the school self administration protocols;
(5) there is written authorization from the student's parent or guardian that the student may self medicate, unless the student has consented to treatment under M.G.L. c. 112,§ 12F or other authority permitting the student to consent to medical treatment without parental permission;
(6) if requested by the school nurse, the licensed prescriber provides a written order for self administration;
(7) the student follows a procedure for documentation of self-administration of prescription medication;
(8) the school nurse establishes a policy for the safe storage of self-administered prescription medication and, as necessary, consults with teachers, the student and parent/guardian, if appropriate, to determine a safe place for storing the prescription medication for the individual student, while providing for accessibility if the student's health needs require it. This information shall be included in the medication administration plan. In the case of an inhaler or other preventive or emergency mediation, whenever possible, a backup supply of the prescription medication shall be kept in the health room or a second readily available location;
(9) the school nurse develops and implements a plan to monitor the student's self-administration, based on the student's abilities and health status. Monitoring may include teaching the student the correct way of taking the prescription medication, reminding the student to take the prescription medication, visual observation to ensure compliance, recording that the prescription medication was taken, and notifying the parent, guardian or licensed prescriber of any side effects, variation from the plan, or the student's refusal or failure to take the prescription medication;
(10) with parental/guardian and student permission, as appropriate, the school nurse may inform appropriate teachers and administrators that the student is self-administering a prescription medication.

BLESSED SACRAMENT SCHOOL

ASTHMA HISTORY FORM

Student's Name: _____ Date of Birth: _____

Parent/Guardian: _____ Homeroom/Grade: _____

Home Phone: ( )_____ Work Phone: ( )_____

Health Care Provider: _____ Phone: ( )_____

When was this student's asthma first diagnosed?_____

How many times has this student been seen in the emergency room for asthma in the past year?_____

How many times has this student been hospitalized for asthma in the past year?_____

Has this student ever been admitted to an intensive care unit for asthma? _____
If so, when? _____

How would you rate the severity of this student's asthma?
(not severe) 1 2 3 4 5 6 7 8 9 10 (severe)

How many days would you estimate this student missed last year because of asthma? _____

What triggers this student's asthma? (check all that apply)

☐ exercise	☐ temperature change	☐ strong odors/fumes	☐ chalk dust
☐ respiratory infection	☐ dust	☐ stress	☐ wood smoke
☐ pollen	☐ molds	☐ carpets	☐ cigarette smoke

☐ animals (specify): _____
☐ foods (specify): _____
☐ other: _____

What does this student do at home to relieve symptoms? (check all that apply)

☐ breathing exercises	☐ rest/relaxation	☐ drinks fluids
☐ takes medication	☐ uses herbal remedies	

☐ other (please describe): _____

What medication does this student take for asthma? (every day and as needed):

Medication Name	Dosage	Delivery Method (nebulizer, inhaler etc.)	Frequency

What herbal remedies, if any, does this student take for asthma? _____

Does this student use any of the following aids for managing asthma?

☐ peak flow meter (personal best if known): _____

☐ spacer ☐ holding chamber ☐ holding chamber with mask

☐ other: _____

Please check special accommodations related to your child's asthma:

☐ physical education class ☐ recess ☐ animals in classroom

☐ avoidance of certain foods ☐ field trips ☐ special hydration needs

☐ other: _____

☐ please provide details: _____

Parent/Guardian Signature: _____ Date: _____

Nurse Signature: _____ Date: _____