School District of Crandon

Asthma Treatment Plan

2024-2025

Asthma Treatment Plan must be completed along with the Medical Authorization Form. All portions of this medical treatment plan must be complete before medication/procedure will be administered by school district personnel.

Student Name: _____ **Date of Birth:** _____

Address: _____ **Phone #:** _____

School: _____ **Grade:** _____ **Teacher:** _____

Asthma Severity: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent
☐ He/she has had many or severe asthma attacks/exacerbations

☺ Green Zone Have the child take these medicines every day, even when the child feels well.

Always use a spacer with inhalers as directed.

Controller Medicine(s): _____

_____

Controller Medicine(s) Given in School: _____

Rescue Medicine: Albuterol/Levalbuterol _____ puffs every four hours as needed

Exercise Medicine: Albuterol/Levalbuterol _____ puffs 15 minutes before activity as needed

😐 Yellow Zone Begin the sick treatment plan if the child has a cough, wheeze, shortness of breath, or tight chest. Have the child take all of these medicines when sick.

Rescue Medicine: Albuterol/Levalbuterol _____ puffs every 4 hours as needed

Controller Medicine(s):

☐ Continue Green Zone medicines: _____

☐ Add: _____

_____

☐ Change: _____

If the child is in the **yellow** zone more than **24** hours or is getting worse, follow **red** zone and call the doctor right away!

☹ Red Zone If breathing is hard and fast, ribs sticking out, trouble walking, talking, or sleeping.
Get Help Now

Take rescue medicine(s) now

Rescue Medicine: Albuterol/Levalbuterol _____ puffs every _____

Take: _____

_____

If the child is not better right away, call 911
Please call the doctor any time the child is in the red zone.

Date: _____

Reviewed By: _____

School District personnel: Follow the **Yellow** and **Red Zone** plans for rescue medication(s) according to asthma symptoms. **Unless otherwise noted, the only medication to be administered in school are those listed as "given in school" in the green zone.**

The School District of Crandon has my written consent to administer medication/procedure as indicated in this treatment plan. I understand that trained, non-medical school personnel shall administer medication/procedure. I agree to hold the School District, its employees or agents who are acting on this request within the scope of their duties, harmless in any and all claims arising from the administration of this medication at school. I authorize the school nurse to exchange information verbally or in writing with my student's physician regarding this medication/procedure or conditions for which it is prescribed.

- For Middle/High School students - my student has been instructed, is capable of self-administration, and has my consent to self-carry inhaler:
  - ☐ Yes ☐ No **(REQUIRES practitioner signature and authorization below before valid.)**

My signature indicates that I have fully read and understand the above information.

Parent/Guardian Signature: _____ Date: _____ Phone #: _____

PHYSICIAN AUTHORIZATION

The physician whose signature follows hereby authorizes school personnel to administer medication/procedure during the school day as prescribed. I agree to accept communication regarding the student/medication/procedure and understand trained, non-medical school personnel will administer the medication/procedure.

Asthma Inhaler: This student has been instructed, is capable of self-administration, and may self-carry inhaler: ☐Yes ☐No

Name of Physician: _____ Physician's Phone #: _____

Clinic Name and Address: _____

Physician's Signature: _____ Date: _____