Wonewoc-Center School District

Home of the Wolves

101 School Road, Wonewoc, WI 53968

JODI WELDY
SCHOOL NURSE

PHONE: (608) 464-3165 ext. 131
FAX: (608) 464-3325

ASTHMA HEALTH PLAN

Student_________________________________ **Date of Birth**______________
Grade__________ **Teacher**__________________ **School Year**_______________
Parent/Guardian___________________________ **Phone Number**_____________
Practitioner_______________________________ **Phone Number**_____________

Severity Classification: ☐ Intermittent (with illness) ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent
☐Student has had many or severe asthma attacks/exaacerbations ☐ No longer a concern
Asthma Triggers____

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

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 ____ 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 ____ 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 _____ 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 child has the knowledge and skills to self-carry and self-administer medicine at school with the approval of the school nurse**

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Please remember that all medications need to be picked up by Parent/Guardian at the end of the year. Unclaimed medication will be discarded.

- I hereby give permission to WC'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 Wonewoc-Center 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 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) and medication consent form(s) on or prior to the first day of school******

Parent Signature: ____**Date:**______________

Reviewed By (School Nurse): ____**Date:** _____________