Piedmont Community Charter School **Asthma Procedures** and Healthcare Provider Order

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

School Year: _____

Medical Provider Signature: **Date:**

Parent Signature: _____ Date: _____

Exercise: Asthma symptoms are triggered by exercise/physical activity □ Yes □ No
If yes:
Use rescue inhaler 2 puffs as needed to prevent symptoms: □ Before very active exercise □ Before PE □ Before Recess

Yellow Zone Symptoms	**Actions**
• Coughing for prolonged periods • Wheezing, musical sounds in chest or other unusual noises with breathing (audible with or without auscultation) • Shortness of breath • Tightness in chest • Can't easily play or exercise • Can do some but not all usual activities	**Have student use their inhaler as prescribed Name of inhaler and Dose:_____ _____puffs, every_____ 1. Remove student from trigger such as activity or allergen 2. Calm student and encourage slow deep breaths 3. Breath through pursed lips (inhale through the nose, exhale twice as slow out of mouth) 4. Sips of cool water 5. If symptoms are not relieved repeat dose as prescribed 6. If inhaler is not available, call the school nurse. 7. Call parent if school nurse is not on campus.
Red Zone (Emergency) Symptoms	**Actions**
• Very short of breath • Breathing is very difficult or very fast • Using neck or stomach muscles to breathe(accessory muscles) • Nostrils are flaring/opening wide to breathe • EXTREME DANGER • Trouble walking or talking • Lips or fingernails are blue (cyanotic)	1. CALL 911 2. Have student use their inhaler as prescribed _____puffs, every_____ 3. Stay with student to monitor breathing. Speak calmly and reassuringly. 4. Encourage student to relax, sit up in a comfortable position, and take slow deep breaths. Offer sips of water ONLY if able to drink safely 5.Contact parent/guardian

Parent/Guardian Signature:_____ Phone number_____:

For School Use Only

Location of Rescue Inhaler: _____

Date inhaler received: _____ Expiration date: _____Number of doses available: _____

□ Staff trained in asthma action plan, medication administration and documentation.

Student authorized to self-medicate and self-carry □ Yes □ No Location of back-up inhaler_____

School Nurse Signature_____ Date_____