

# ASTHMA/REACTIVE AIRWAY ACTION PLAN

Health Services Department  
Lincoln Public Schools • Lincoln, Nebraska

Student Name: \_\_\_\_\_ ID#: \_\_\_\_\_ Grade: \_\_\_\_\_

### INFORMATION FOR PARENTS AND GUARDIANS

Your student's health record shows a history of Asthma/Reactive Airway Disease or use of asthma medications.

Please check here and sign if your student has been symptom free and has not used any asthma medications for the past 3 years.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

**STOP HERE if you checked this box. Return form to Health Office.**

### Check the triggers that cause your student to have breathing problems:

- Exercise
- Strong odors or fumes
- Molds
- Respiratory Infections/Colds
- Pollens
- Emotional Triggers
- Change in Temperature/Weather
- Plants
- Smoke
- Animals \_\_\_\_\_
- Food \_\_\_\_\_
- Other \_\_\_\_\_

### Check the symptoms your student has when he/she is having breathing problems:

- Cough
- Shortness of Breath
- Restlessness
- Wheeze
- Anxiety
- Complaints of Chest Tightness
- Other \_\_\_\_\_

| MEDICATIONS USED EVERY DAY: GREEN ZONE | DOSE/ROUTE | TIMES/DAY |
|--|------------|-----------|
|  |            |           |
|  |            |           |
|  |            |           |
|  |            |           |
|  |            |           |

LPS form HS0019 (Request to Provide Medications) must be completed for medications administered at school.

| QUICK-RELIEF/RESCUE MEDICATIONS: YELLOW ZONE / RED ZONE | DOSE/ROUTE | TIMES/DAY |
|---|------------|-----------|
|   |            |           |
|   |            |           |
|   |            |           |

| BEFORE EXERCISE/ACTIVITY, IF NEEDED TAKE: | DOSE/ROUTE | TIMES/DAY |
|---|------------|-----------|
|   |            |           |
|   |            |           |
|   |            |           |

Instructions/Additional Activity Accommodations:

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**SCHOOL EMERGENCY & SAFETY PLAN:** Please share information for a school evacuation, relocation or lock down situation (ex. Parent will provide an extra rescue inhaler to be kept in classroom).

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Please attach a copy of any asthma plan provided by your licensed medical provider.

Name of medical provider: \_\_\_\_\_

Parent/Guardian name: \_\_\_\_\_

Best contact phone number: \_\_\_\_\_

Parent/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

**This form is requested annually if:**

- Your student has had an asthma-type episode in the last three years, and/or
- Your student currently uses medication to improve breathing, and/or
- Your student has been in the hospital or the emergency room for breathing problems in the last three years.
- This information is important to keeping your student safe, and providing correct emergency response at school.
- It is a priority for us to have current emergency contact information for you.
- Written authorization from your student’s licensed medical provider is required for medically necessary cares at school (if any needed, including medications). **New authorization is needed for each school year and/or when medical orders change.**
- The school nurse may contact you or your student’s licensed medical provider if additional information or clarification is needed for cares at school.
- Information will be shared as appropriate with other school and emergency personnel to benefit your student’s safety and success.
- Self-Management of Asthma and/or the carrying of medications requires additional consents. Contact your school nurse.
- If you have questions, please contact the school nurse at your student’s school.

**OFFICE USE ONLY**

| DATE | ANNUAL REVIEW COMMENTS |
|------|------------------------|
|      |                        |
|      |                        |