Montana Student Asthma Action Plan

Student_____ School Nurse/Emergency Staff Phone_____ Fax _____
Teacher_____ Parent/Guardian_____ Phone_____
Student's Healthcare Provider_____ Phone_____ Fax_____

Green Zone	**Student is feeling well** • No difficulty participating in usual activities • No chest tightness, shortness of breath, wheezing, or coughing during the day or night Take these controller medications every day: Medicine _____ Dosage _____ When to Take it _____ _____ _____ _____ _____ _____ _____ Before exercise: Medication _____ Dosage _____ ____minutes prior to activity
Yellow Zone	**Student is not feeling well** • Chest tightness, shortness of breath, wheezing, or coughing with usual activities • Waking at night due to asthma symptoms Continue taking controller medication(s) and add these quick-relief medications: Medicine _____ Dosage _____ When to Take it _____ _____ _____ _____ Call student's healthcare provider if: _____ _____
Red Zone	**Alert! Contact student's healthcare provider or call 911 if:** • Quick-relief medication is not helping • Breathing is hard and fast • Ribs are showing and nostrils are flaring • Can't walk or talk well Take the following medications, and call the healthcare provider or contact EMS right away: Medicine _____ Dosage _____ When to Take it _____ _____ _____ _____

Other key medical information

☐ Student self-carries rescue medication ☐ Rescue medication is stored _____
The student's asthma triggers are _____
_____

Reviewed by parent/guardian _____ Date _____
Reviewed by school nurse/emergency staff _____ Date _____
Reviewed by student's healthcare provider _____ Date _____

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Montana Authorization to Possess or Self-Administer Asthma, Severe Allergy, or Anaphylaxis Medication

For this student to possess or self-administer asthma, severe allergy, or anaphylaxis medication while in school, while at a school sponsored activity, while under the supervision of school personnel, before or after normal school activities (such as while in before-school or after-school care on school-operated property), or while in transit to or from school or school-sponsored activities, this form must be fully completed by 1) the prescribing physician/physician assistant/advanced practice registered nurse, and 2) an authorizing parent, an individual who has executed a caretaker relative educational or medical authorization affidavit, or legal guardian.

Student's Name:_ School:
Sex: (Please circle) Female / Male City/Town:
Birth Date: School Year: (Must be renewed annually)

Authorization by Physician/PA/APRN:

The above-named student has my authorization to carry and self administer the following asthma, severe allergy, or anaphylaxis medication:
Medication: (1) Dosage: (1)

(2) (2)

Reason for prescription(s):
Medication(s) to be used under the following conditions (times or special circumstances):

I confirm this student has been instructed in the proper use of this medication and is able to self-administer this medication without school personnel supervision. I have formulated and provided to the parent/guardian or caretaker relative a written treatment plan for managing asthma, severe allergies, or anaphylaxis episodes and for medication use by this student during school hours and school activities.

Signature of Physician/PA/APRN Phone Number Date

Authorization by parent, individual who has executed a caretaker relative educational or medical authorization affidavit, or guardian:
As the parent, individual who has executed a caretaker relative educational or medical authorization affidavit, or guardian of the above named student, I confirm this student has been instructed by his/her healthcare provider on the proper use of this/these medication(s). He/she has demonstrated to me he/she understands the proper use of this medication. He/she is physically, mentally, and behaviorally capable to assume this responsibility. He/she has my permission to self-medicate as listed above, if needed. If he/she has used epinephrine during school hours, he/she understands the need to alert the school nurse or other adult at the school who will provide follow-up care, including making a 9-1-1 emergency call.

I acknowledge the school district or nonpublic school and its employees and agents are not liable as a result of any injury arising from the self-administration of medication by the student, and I indemnify and hold them harmless for such injury, unless the claim is based on an act or omission that is the result of gross negligence, willful and wanton conduct, or an intentional tort.

I agree to work with the school in establishing a plan for use and storage of backup medication. This will include a predetermined location to keep backup medication to which the student has access in the event of an asthma, severe allergy, or anaphylaxis emergency. I have provided the following backup medication:

I understand in the event the medication dosage is altered, a new "self-administration form" must be completed, or the health care provider may rewrite the order on his/her prescription pad and I, the parent/caretaker relative/guardian, will sign the new form and assure the new order is attached.

I understand it is my responsibility to pick up any unused medication at the end of the school year, and any medication not picked up will be disposed of.

I authorize the school administration to release this information to appropriate school personnel and classroom teachers.

Parent/Caretaker/Guardian relative signature: Date:
(Original signed authorization to the school; a copy of the signed authorization to the parent/guardian and health care provider)
See generally Mont. Code Ann. § 20-5-420