Asthma Action Plan for New Mexico Schools

School District: _____ School Name: _____ SY: _____

Parent/Guardian: Please complete information in top section and sign consent at bottom of page, then submit to School Nurse.

Student Name: _____ DOB: _____ Student School ID: _____
Parent/Guardian: _____ Ph: _____ Emergency Contact: _____ Ph: _____
Healthcare Provider Name / Title: _____ Phone: _____

Healthcare Provider: Please complete information below and sign/date the order authorization at bottom of page.

Asthma Severity: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Asthma Triggers Identified: ☐ Exercise ☐ Colds ☐ Smoke ☐ Dust ☐ Pollen ☐ Odors ☐ Mold/Moisture ☐ Stress ☐ Pests ☐ GERD ☐ Food Allergies ☐ Animals ☐ Other: _____

Green Zone (Healthy): Take control medication(s) every day to prevent symptoms. Daily/routine med(s) orders:



- Breathing is good
- Sleeping well
- Can work and play
- No cough or wheeze

□ Medication: _____, _____ puff(s), _____ times per day
□ Medication: _____, via nebulizer, _____ times per day
□ Oral Medication: _____, Dose: _____, ____ times per day
Medications above are usually given at home before/after school day.

If exercise triggers your asthma, use preventative treatment before vigorous activity:
□ Medication: _____, ____ puff(s), _____ minutes prior to exercise
*** Not to exceed treatment once every 4 hrs***

** Metered dose inhalers work best with spacers * Use mask with spacer/nebulizer if prescribed * Rinse mouth after inhaler use*

Yellow Zone (Caution): Continue green zone medications and add rescue medications per these orders:



- First signs of a cold
- Cough or wheeze
- Chest tightness
- Exposure to trigger

Rescue medication name and type: *** Call parent/guardian if giving these meds*
□ Medication: _____, ____ puff(s) every ____ minutes/hours PRN *(Circle one)*
□ Medication: _____, via nebulizer every ____ minutes/hours PRN *(Circle one)*

****If you are getting worse or not improving after treatment(s) GO TO RED ZONE****
Note: Using a rescue inhaler more than twice a week may indicate poor asthma control; follow-up with a primary care provider is advised.

Red Zone (Emergency): Do not leave student alone. Call 911 and start treatment ordered below NOW:



- Can't talk, walk, eat well
- Medicine not helping
- Breathing hard/fast -ribs may be showing
- Blue lips and fingernails
- Tired/lethargic
- Non-stop cough

Administer rescue medication (type/name and order):
_____, _____ puff(s)/nebulizer every ___ minutes until EMS arrives

****For schools that stock Oxygen or if student has Oxygen orders:*** *(Only use Oxygen if Pulse Oximeter available); give 02 to keep sat. above 92% unless otherwise contraindicated and check sat. continually until EMS arrives; or follow student's O2 orders.*

School Medication Consent and Healthcare Provider Order:

□ Student has demonstrated the ability to safely and effectively self-carry and self- administer inhaled asthma medication.
□ Student needs assistance & should not self–carry.

_____ _____
MD/ DO/NP/PA Signature **Date**

Parent/Guardian:
I approve of this asthma action plan. I give my permission for the school nurse and trained school personnel to follow this plan, administer medication(s), and contact my provider, if necessary, and share this plan with the SBHC, if applicable. I assume full responsibility for providing the school with the prescribed medications and delivery of monitoring devices. I give my permission for the school to share the above information with school staff that need to know and permission for my child to participate in any asthma educational learning opportunities at school.
Parent/Guardian Signature: _____ Date: _____
School Nurse Signature: _____ Date: _____

Original 2016; revised 2025

Student-Parent/Guardian Instructions

The NM Asthma Action Plan for Schools is designed to help everyone understand the steps necessary for the individual student to achieve the goal of controlled asthma.

1. **Parents/Guardians:** *Before taking this form to your Health Care Provider*, complete the top section with:
   - Child's name
   - Child's doctor's name & phone number
   - Parent/Guardian's name
   - Child's date of birth
   - An Emergency Contact person's name and phone number
2. **Your Health Care Provider** will complete the following areas:
   - The asthma severity level of your child's asthma
   - The effective date of this plan
   - The medicine and dosage information for the Green (Healthy), Yellow (Caution), and Red (Emergency) zones/sections
3. **Parents/Guardians & Health Care Providers together** will discuss and then complete & sign the following areas:
   - Child's asthma triggers near the top of the form
   - Health care provider order and school medication consent section at the bottom of the form: Discuss your child's ability to self-administer the inhaled medications, check the appropriate box, and then both you and your Health Care Provider must sign and date the form
4. **Parents/Guardians:** *After completing the form with your Health Care Provider:*
   - Make copies of the Asthma Action Plan and give the signed original to your child's school nurse or child care provider
   - Keep a copy easily available at home to help manage your child's asthma
   - Give copies of the Asthma Action Plan to everyone who provides care for your child, for example: babysitters, before/after school program staff, coaches, scout leaders
   - Call your child's doctor for control concerns or if rescue medication is used more than 2 times per week for asthma symptoms

For asthma or any medical condition, seek medical advice from your or your child's health care professional.

FILL OUT THE SECTION BELOW IF YOUR HEALTH CARE PROVIDER CHECKED PERMISSION FOR YOUR CHILD TO SELF-ADMINISTER ASTHMA MEDICATION ON THE FRONT OF THIS FORM.
RECOMMENDATIONS ARE EFFECTIVE FOR ONE (1) SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY

☐ **I DO** request that my child be ALLOWED to carry the following medication for self-administration in school pursuant to NMAC 6.12.2.9. I give permission for my child to self-administer medication, as prescribed in this NM Asthma Action Plan for Schools for the current school year as I consider them to be responsible and capable of transporting, storing and self-administration of the medication. Medication must be kept in its original prescription container. I understand that the school district, agents and its employees shall incur no liability as a result of any condition or injury arising from the self-administration by the student of the medication prescribed on this form. I indemnify and hold harmless the School District, its agents and employees against any claims arising out of self-administration or lack of administration of this medication by the student.

☐ **I DO NOT** request that my child self-administer their asthma medication.

Parent/Guardian Signature	Phone	Date