

Please return to School Nurse: _____ School: _____ Fax: _____

ASTHMA ACTION PLAN

Child's Name: _____ Birthdate: _____ Grade: _____

The following is to be completed by the PHYSICIAN:

1. Asthma severity (circle one): Mild Intermittent Mild Persistent Moderate Persistent Severe Persistent

2. Medications (at school AND home): Circle One Below:

A. "QUICK-RELIEF" Medication Name		MDI, Oral, Nebulizer	Dosage or # of Puffs
1.	_____	MDI, Oral, Nebulizer	_____
2.	_____	MDI, Oral, Nebulizer	_____
B. ROUTINE Medication Name (e.g., anti-inflammatory)		MDI, Oral, Nebulizer	Dosage or # of Puffs Time of day
1.	_____	MDI, Oral, Nebulizer	_____
2.	_____	MDI, Oral, Nebulizer	_____
C. BEFORE P.E. Exertion: Medication Name		MDI, Oral, Nebulizer	Dosage or # of Puffs
1.	_____	MDI, Oral, Nebulizer	_____
2.	_____	MDI, Oral, Nebulizer	_____

3. For student on inhaled medication (all students must go to health office for oral medications)

- Assist student with medication in office Remind student to take medication May carry own medication, **if responsible** ◀◀

4. Circle Known Triggers: tobacco pesticide animals birds dust cleansers car exhaust perfume mold
cockroach cold air cleansers exercise Other: _____

5. Peak Flow: Write patient's 'personal best' peak flow reading under the 100% box (below); Multiply by .8 and .5 respectively

100%	Green Zone	80%	Yellow Zone	50%	Red Zone
Peak flow = _____	No Symptoms	Peak flow = _____	<i>Starting to cough, wheeze or feel short of breath.</i> <u>Action for home, school:</u> Give 'Quick-Relief' Med; Notify parent <u>Action for Parent/MD:</u> Increase controller dose _____	Peak flow = _____	<u>Cough, short of breath, trouble walking or talking</u> <u>Action for home or school:</u> <i>Take Quick-Relief Meds;</i> • If student improves to 'yellow zone' send student to doctor or contact doctor. • If student stays in 'red zone' begin Emergency Plan.

School Emergency Plan: If student has: a) No improvement 15 – 20 minutes **AFTER** initial treatment with quick-relief medication; or b) peak flow is < 50% of usual best, or c) Trouble walking, or talking; or d) Chest/neck muscle retract with breaths, hunched, or blue color;
Then: 1. Give quick-relief meds; Repeat in 20 min if help not arrived; 2. Seek emergency care (911); 3. Contact parent.
In yellow or red zone? Students with symptoms who need to use 'quick-relief' meds may frequently need change in routine 'controller' medication. Schools must be sure parent is aware of each occasion when student had symptoms and required medication.

►►Physician's Name (print) _____ Signature _____ Date: _____

Office Address: _____ Office Telephone No.: _____
Includes nurse practitioner or other health care provider as long as there is authority to prescribe.

A form that permits school and health care provider to exchange information must accompany this form

Parent's/Guardian's Signature _____ Date: _____ Home Telephone Number: _____

Emergency Telephone Number(s) / Names of contact: _____

**THE FOLLOWING IS TO BE COMPLETED BY THE PARENT OR GUARDIAN
REQUESTING MEDICATION IN SCHOOL :**

- An adult must deliver the medication and this completed form to the school.
- An adult must pick up any unused medication on or before the last school day of the year.
- This form will be completed again by the doctor every year (or more often if the doctor has put a time limit on the prescription).

I request that the school nurse or other designated person administer medication as directed by the physician. I authorize the school nurse to communicate with the prescribing physician, if I am notified, when the school or physician wants more information about school asthma symptoms or management. I agree to save and hold the district, its officers, employees or agents harmless from liability, suits or claims, of whatever nature or kind which might arise as a result of administering the medication in accord with this request.

Parent's/Guardian's Signature: _____

Date: _____

Emergency Telephone Number (s) / Names of Contact
