School Information

Asthma Action Plan for Schools and Families

Health Care Provider Information

Last Name: _____ First Name: _____

Date of Birth (mm/dd/yyyy): _____ Medical Record #: _____

School Name: _____ School Contact Phone #: _____

Parent/Guardian Name: _____ Parent/Guardian Phone #: _____

Emergency Contact: _____ **Emergency Phone #:** _____

Health Care Provider Name: _____ Health Care Provider Phone #: _____

To be completed by health care provider: **Asthma Severity:** ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

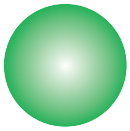
Attention Parent/Guardian/School Personnel: ANY student with asthma (of any severity) can have a severe asthma attack.

Asthma symptoms are triggered by: ☐ **Exercise** ☐ **Dust** ☐ **Animal dander** ☐ **Strong Odors or Fumes** ☐ **Mold** ☐ _____

Green Zone

Personal Best Peak Flow (PF) _____ Date: _____

Peak flow is between_____ (80% of personal best) and _____ (100% of personal best)



1. Take CONTROLLER medication(s) (at home) EVERY DAY:

Take _____ (Name of Medicine) inhaler_____ (How much) puffs _____ (How often) times/day.

Take _____ (Name of Medicine) inhaler _____ (How much) puffs _____ (How often) times/day.

If asthma is triggered by exercise (at school or home), take ☐ Albuterol or _____ (Name of Medicine) inhaler_____ (How much) puffs at least _____ minutes before exercise. Restrictions or activity limitations: _____

Yellow Zone-Caution! DO NOT LEAVE STUDENT ALONE!

Peak flow is between_____ (50% of personal best) and _____ (80% of personal best).

1. Begin QUICK RELIEF medication (at school or home) right NOW:

Take ☐ Albuterol or _____ (Name of Medicine) inhaler _____ (How much) puffs **OR** _____ (Name of Medicine) solution _____ (How much) ml by nebulizer.

- If symptoms are better or if the peak flow is improved within ☐ 15 minutes/_____minutes, THEN repeat QUICK RELIEF MEDICATION (as listed above in 1) every _____ (Number) hours for _____ (Number) days.
- If symptoms are **NOT** better or if the peak flow is **NOT** improved, go to Red Zone.

☐ **Attention School: Call Parent/Guardian when quick relief medication has been administered by student and/or staff.**

2. Attention Parent/Guardian (Home Instructions):

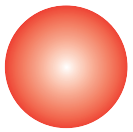
☐ Call your child's Health Care Provider

☐ Continue to take CONTROLLER medication (at home) everyday as written above in *Green Zone* instructions.

☐ Increase CONTROLLER medication:

Take _____ (Name of Medicine) inhaler_____ (How much) puffs _____ (How often) times/day for _____ (Number) days.

Red Zone-Medical Alert! Get Help! DO NOT LEAVE STUDENT ALONE! Peak flow is below_____ (50% of personal best).



1. Take QUICK RELIEF medication (at school or home) right NOW:

Take ☐ Albuterol or _____ (Name of Medicine) inhaler _____ (How much) puffs **OR** _____ (Name of Medicine) solution ____ (How much) ml by nebulizer and **REPEAT EVERY 20 MINUTES UNTIL PARAMEDICS ARRIVE!**

- **Call 9-1-1 immediately and call Parent/Guardian**

2. Attention Parent/Guardian (Home Instructions):

☐ Call your child's Health Care Provider. ☐ Continue CONTROLLER medication (at home):

Take _____ (Name of Medicine) inhaler_____ (How much) puffs _____ (How often) times/day for _____ (Number) days.

☐ And ADD_____ (Name of Medicine) _____ (How much) mg orally once daily for_____ (Number) days.

Authorization and Disclaimer from Parent/Guardian: I request that the school assist my child with the above asthma medications and the Asthma Action Plan in accordance with state laws and regulations. Yes ☐ No ☐

My child may carry and self-administer asthma medications and I agree to release the school district and school personnel from all claims of liability if my child suffers any adverse reactions from self-administration of asthma medications: Yes ☐ No ☐

_____ Parent/Guardian Signature _____ Date

Health Care Provider: My signature provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. Student may carry and self-administer asthma medications: Yes ☐ No ☐ (This authorization is for a maximum of one year from signature date.)

_____ Healthcare Provider Signature _____ Date

California Asthma Public Health Initiative, California Department of Health Services