

ASTHMA ACTION PLAN

Student's Name: _____	Date of Birth: _____	Grade: _____
School: _____	Phone #: _____	Fax #: _____

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):**

Medication	Route	Dosage	Frequency
<i>A. QUICK-RELIEF</i>			
1.			
2.			
<i>B. ROUTINE (e.g. anti-inflammatory)</i>			
1.			
2.			
<i>C. BEFORE P.E. Exertion</i>			
1.			

3. **For Student on Inhaled Medication:** 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 cleanser exercise other: _____

5. **Peak Flow:** Write student's 'personal best' peak flow reading under the 100% box (below); multiply by 0.8 and 0.5 respectively

100%	Green Zone	80%	Yellow Zone	50%	Red Zone
Peak Flow # = _____	No Symptoms	Peak Flow # = _____	Starting to cough, wheeze or feel short of breath. Action for home, school: Give "Quick-Relief" med; notify parent Action for Parent/MD: Increase controller dose _____	Peak Flow # = _____	Cough, short of breath, trouble walking or talking Action for home or school: Take Quick-Relief Meds; • 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 medication; Repeat in 20 minutes if help has not arrived; 2. Seek emergency care (911); 3. Contact parent
Students with symptoms who need to use "quick-relief" meds may frequently need change in routine "controller" medications. Schools must be sure parent is aware of each occasion when student had symptoms and required medication.

Physician's Name (print): _____	Signature: _____	Date: _____
Office Telephone #: _____	Office Fax #: _____	

I authorize the school nurse, or other appropriately assigned school staff, to administer the medication/perform the procedure, as prescribed here in by the authorized health care provider. I will notify the school immediately and submit a new form, if there are any changes in the medication, procedure or the prescribing physician. I understand that school health staff are obliged by law to clarify issues associated with this order with the prescribing provider as necessary.

Parent/Guardian Signature: _____ **Date:** _____

School Nurse Signature: _____	Date: _____
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