**ASTHMA ACTION PLAN**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Student Name: | |  | Date of birth: | |  | | Grade: |  |  |
| School: |  | | Phone #: |  | | Fax #: |  | |  |
|  |  | |  |  | |  |  | |  |

**The following is to be completed by the PHYSICIAN:**

**1. Asthma Severity (check one):**  Mild Intermittent  Mild Persistent  Moderate Persistent  Severe Persistent

**2. Medications (at school AND home):**

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

**3.** **For Student on Inhaled Medication:**   assist student with medication in office  remind student to take medication

**may carry own medication, if responsible**

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**4**. **Check Known Trigger**s:  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

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| --- | --- | --- | --- | --- | --- |
| **100%** | **Green Zone**  No  Symptoms | **80%** | **Yellow Zone**  **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 | **50%** | **Red Zone**  **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. |
| Peak  Flow  # = | Peak  Flow  # = | Peak  Flow  # = |

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| **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. |

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| **Physician’s Name (print):** | |  | | | **Signature:** | |  | | | **Date:** | |  |  |
| **License No.:** |  | | **NPI #:** |  | | **Office Telephone #:** | |  | **Office Fax #:** | |  | |  |
|  | | | | | | | | | | | | | |

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| 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:** |  |  |
|  |  |  |  |  |

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| --- | --- | --- | --- | --- |
| **School Nurse Signature:** |  | **Date:** |  |  |
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