**ASTHMA ACTION PLAN**

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| Student Name: |       | Date of birth: |       | Grade: |       |  |
| School: |       | Phone #: |       | Fax #: |       |  |
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**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**NoSymptoms |  **80%** | **Yellow Zone****Starting to cough, wheeze or** **feel short of breath.**Action for home, school: Give ‘Quick-Relief’ med;notify parentAction 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’ sendstudent to doctor or contact doctor.• If student stays in ‘red zone’ begin Emergency Plan. |
| PeakFlow# =         | PeakFlow# =         | PeakFlow# =      |

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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 colorThen: 1. Give quick-relief medication; Repeat in 20 minutes if help has not arrived; 2. Seek emergency care (911); 3. Contact parentStudents with symptoms who need to use “quick-relief” meds may frequently need change in routine “controller” medications. Schools must besure 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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