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 Frequency
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 Frequency
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%		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 meds; Repeat in 20 min if help has 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.

Page 2 of this form, that permits school and health care provider to exchange information, must be included.

******RCSN Reviewed Order:_____ Date:_____

Parents/Guardians Signature: _____ Date: _____ Home Telephone #: _____

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

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/Guardian Signature: _____ Date: _____

Emergency Telephone Number(s)/Name(s) of Contact(s)

_____

_____

_____