



Please return to School Nurse School: \_\_\_\_\_ Fax: \_\_\_\_\_

ASTHMA ACTION PLAN

Child's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Grade: \_\_\_\_\_ Room #: \_\_\_\_\_

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):

Table with 3 columns: Medication Name, MDI, oral, neb?, Dosage or No. of Puffs. Rows include QUICK-RELIEF, ROUTINE, and BEFORE P.E. Exertion.

- 3. For student on inhaled medication (all students must go to health office for oral medications)
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.

Table with 5 columns: 100% Green Zone, 80% Yellow Zone, 50% Red Zone. Includes instructions for each zone.

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 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.

A form that permits school and health care provider to exchange information must accompany this form

Parent's/Guardian's Signature \_\_\_\_\_ Date: \_\_\_\_\_ Home Telephone Number: \_\_\_\_\_

Emergency Telephone Number(s) / Names of contact: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Grade: \_\_\_\_\_

**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's/Guardian's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Emergency Telephone Number (s) / Names of Contact

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