CONFIDENTIAL
Hawthorne School District

Asthma Action Plan

Please complete both sides of this form and return to school.

Dear Parents/Guardians,

You and your child's healthcare provider needs to complete the form below and return it to the health office. This will allow us to provide adequate care for your child in the event of an "asthma attack" at school. In the absence of this completed form, we will use the information provided on your child's enrollment form. For your child's safety, we prefer this individualized plan from you and your healthcare provider. We thank you for helping us to provide quality care for your child.

__Asthma Action Plan__ (includes Authorization for Asthma Medications at School)

Child's Name: ______________________ Age: ________ Birth date: ___/___/___ Grade: ________ School Year: 20__/20__

Name of School: ______________________ Principal: ______________________ Teacher: ______________________ Room#: ______

The following is to be completed by the HEALTHCARE PROVIDER:

A. QUICK-RELIEF (Rescue) Medications e.g. albuterol: Meds to give for Peak Flow <80% or other symptoms)

	Med Name	MDI, oral, neb?	Dosage or No. of Puffs
1.			
2.			

B. ROUTINE (Controller) Medications (whether given at school or at home):

	Med Name	MDI, oral, neb?	Dosage or No. of Puffs	Time of Day
1.				
2.				

C. Medications BEFORE PE Exertion:

	Med Name	MDI, oral, neb?	Dosage or No. of Puffs
1.			
2.			

__Peak Flow:__ Write patient's personal best peak flow reading under the 100% box (below): Then multiply by .8 and .5 respectively to define the Green, Yellow and Red Zones:

100%	Green Zone	80%	Yellow Zone *Take Rescue Meds*	50%	Red Zone *Take Rescue Meds and begin Emergency Plan*

__**Check the items that start an asthma attack with this student:**__

- ☐ Exercise
- ☐ Changes in temperature
- ☐ Strong odors/fumes
- ☐ Animals
- ☐ Carpet
- ☐ Pollen
- ☐ Respiratory infections/Allergens
- ☐ Food (what kind) ______________________
- ☐ Other ______________________

__**Emergency Plan at School:**__ School staff will give rescue medication, contact parent/guardian and/or seek emergency care (dial 911) if the student has any of the following:

- No improvement 15-20 minutes AFTER initial treatment with rescue medication
- Breathing: chest/neck muscle retract, hunched, blue color
- Peak flow is <50% of usual best
- Trouble walking, talking, or stops playing

Healthcare Provider: ______________________ Signature: ______________________ Date: ___/___/___
PRINT

Office Address: ______________________ Office Telephone #: (   ) ______________

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.
- **Renew this form annually** or earlier if healthcare provider has put a time limit on the prescription.

I request that the school nurse, health clerk or other designated personnel administer medications as directed by the healthcare provider (above). I authorize school health professional to communicate with prescribing healthcare providers and if there are inquiries regarding school asthma management. I agree to save and hold the district, its officers, employees or agents, harmless from any/all liability, suits or claims of personal injury, bodily injury, sustained or claimed to have been sustained, as a result of administering the medication in accord with this request.

Parent's/Guardian's Signature______________________ Date: ___/___/___ Home Telephone # (   ) ______________

Emergency Telephone Number(s) (   ) ______________ Name of Contact ______________________

(   ) ______________ Name of Contact ______________________