Asthma Action Plan

Child's Name:_____ Birthdate:_____ Grade: ___ School: Grant Community High School

The following is to be completed by the PHYSICIAN:

1. Asthma severity (circle one): _mild intermediate _mild persistent _moderate persistent _severe persistent

2. Medications (at school AND home):

A. QUICK-RELIEF" Medication Name	MDI, oral, neb?	Dosage or No. of Puffs
1. _____		
2. _____		
B. ROUTINE Med Name (eg, anti-inflammatory)	MDI, oral, neb?	Dosage or No. of Puffs Time of day
1. _____		
2. _____		
C. BEFORE PE, EXERTION Medication Name	MDI, oral, neb?	Dosage or No. of Puffs
1. _____		
2. _____		

3. For student on inhaled medication (all students must go to NURSES' OFFICE for oral medications):
[ ] Assist student with medication in office [ ] 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%	**Yellow Zone**	50%	**Red Zone**
Peak flow = _____	No Symptoms	Peak flow = _____	**Starting to cough, wheeze or feel short of breath.** *Action for home or 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, b) Peak flow of < 50% of usual best, c) trouble walking, or talking, or d) chest/neck muscle retractions with breaths, hunched, or blue color, then: 1) Give quick-relief meds; repeat in 20 minutes, 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 frequently may need change in routine controller medication. Schools must be sure parent is aware of each occasion when student had symptoms and requires medication.

Physician's† Name (print): _____ Signature: _____ Date:_____

Office Address: _____ Office Telephone: _____

†Includes nurse practitioner or other health care provider as long as there is authority to prescribe.

My child requires medication that must be taken during school hours. I authorize the school to supervise the administration of this medication in accordance with the physician's direction. I understand that my signature on this form constitutes a waiver by me to the staff, school district, its board and members, and other school personnel for liability for unexpected reactions when the medication is administered as ordered.

Parent/Guardian Signature: _____ Date: _____