

Washington International School

3100 Macomb Street NW • Washington, DC 20008
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Asthma Action Plan

Name _____

Severity Classification <input type="checkbox"/> Mild Intermittent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent	Triggers <input type="checkbox"/> Colds <input type="checkbox"/> Smoke <input type="checkbox"/> Exercise <input type="checkbox"/> Dust <input type="checkbox"/> Animals <input type="checkbox"/> Food <input type="checkbox"/> Pollen <input type="checkbox"/> Weather <input type="checkbox"/> Other _____	Exercise Pre-medication (how much/when) _____ Exercise modifications _____
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GREEN ZONE: DOING WELL

Personal Best Peak Flow: _____ **Peak flow in this area:** _____ **to** _____

Symptoms <ul style="list-style-type: none"> • Breathing is good • No cough or wheeze • Can work and play • Sleeps all night 	<input type="checkbox"/> No control medication required <input type="checkbox"/> Control medication required Provide name of medication, dosage, and administration schedule: _____
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YELLOW ZONE: CAUTION

Peak flow between 50-80% of personal best or between _____ **and** _____

Symptoms <ul style="list-style-type: none"> • Some problems breathing • Cough, wheezing or tight chest • Problems working or playing 	<input type="checkbox"/> Rescue medication required Provide name of medication, dosage, and route of administration: _____ _____ _____ Inhaler _____ Inhaler with spacer _____ Nebulizer
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RED ZONE: EMERGENCY

Peak flow is less than 50% of personal best or less than _____ **CALL "911"**

Any of these symptoms <ul style="list-style-type: none"> • Cannot talk, eat, or walk well • Medicine not working • Breathing hard and fast • Blue lips and finger-nails • Tired or lethargic • Ribs showing 	<input type="checkbox"/> Rescue medication required Provide instructions for medication intervention while awaiting rescue squad _____ _____ _____
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SCHOOL MEDICATION CONSENT AND PROVIDER ORDER FOR CHILDREN/YOUTH AS REQUIRED BY DC LAW A17-107, STUDENT ACCESS TO TREATMENT ACT OF 2007

Healthcare Provider Initials:
 _____ This student is capable and approved to self-administer the medicine(s) named above.
 _____ This student is **not** approved to self-medicate.

Provider Signature _____ **Date** _____

As the Responsible Person:
 _____ I hereby authorize a trained school employee to administer medication to the student.
 _____ I hereby authorize the student to possess and self-administer medication.
 _____ I understand that this student is **not** authorized to self-administer medication.

I agree that the school and its employees shall incur no liability and shall be held harmless against any claims that may arise relating to the administration, supervision, training, or self-administration of medication.

Parent Signature _____ **Date** _____