EL PASO COUNTY SCHOOL HEALTH SERVICES
PRACTITIONER'S WRITTEN ORDER/ASTHMA ACTION PLAN

I. PHYSICIAN SECTION

Student Name: _____ DOB: ID#: Grade:

School Year: 20 _____ -20 _____ School Name: _____

Medical Diagnosis: _____

Asthma Severity	Triggers	Exercise
☐Intermediate ☐Mild ☐Moderate ☐Severe	☐Colds ☐Smoke ☐Weather ☐Exercise ☐Dust ☐Air ☐Pollution ☐Animals ☐Food ☐Other	Physician recommendations for Air Quality Alert Days: (*Check One*) ☐No outdoor exercise ☐Limited outdoor activity (no sprints, running, etc.) ☐Exercise as tolerated

GREEN ZONE

Peak Flows _____ to _____ (peak flow between 80-100% of personal best)

☐No control medicines required **OR**

Oral control medication _____ taken _____ times a day.

_____ puff(s) _____ HFA _____ times a day.

_____ nebulizer treatment(s) _____ times a day.

For asthma with exercise: _____ puff(s) _____ 15-20 minutes before exercise.

YELLOW ZONE

Peak Flows _____ to _____ (peak flow between 50-80% of personal best): Tightness to chest, cough or mild wheeze, signs of upper respiratory illness, unable to exercise

_____ puff(s) _____ HFA every _____ hours as needed **OR**

_____ nebulizer treatment(s) every _____ hours as needed.

Comments or special Instructions:

RED ZONE

Peak Flows below _____ (peak flow less than 50% of personal best): EMERGENCY ACTION IS NECESSARY WHEN THIS STUDENT HAS SYMPTOMS SUCH AS: • Can't talk, eat or walk well • Medicine is not helping • Chest/neck retractions • Breathing hard & fast • Blue lips and/or fingernails

PO2 Less than_____%

_____ puff(s) _____ HFA every _____ minutes for _____ treatments **OR**

_____ nebulizer treatment every _____ minutes for _____ treatments.

☐ Call 911

Comments or special Instructions: _____

Additional Medications:

Name	Dosage	Frequency

Medical Equipment: Please list any medical equipment this student will need to treat his/her asthma at school. (i.e., spacer, oxygen, nebulizer, etc.)

☐Yes ☐No

I, the signed physician, certify that the student has asthma and is capable of carrying and self-administering the above quick-relief asthma medication.

Physician's Signature _____ Date _____

II. PARENT/GUARDIAN SECTION/SECCION DE PADRES/TUTOR

Student Name: _____ DOB: _____ ID# _____ Grade: _____
(Nombre del Estudiante) (Fecha de Nacimiento) (# de Indentificion) (Grado)

Parent/Guardian Name: _____ Phone Number: _____ Cell Number: _____
(Nombre del Padre/Tutor) (# de Telefono) (Celular)

Parent/Guardian Name: _____ Phone Number: _____ Cell Number: _____
(Nombre del Padre/Tutor) (# de Telefono) (Celular)

Emergency Contacts/Contactos de Emergencia:

Name: _____ Phone Number: _____ Relation: _____
(Nombre) (# de Telefono) (Relacion)

Name: _____ Phone Number: _____ Relation: _____
(Nombre) (# de Telefono) (Relacion)

Parent/Guardian Authorization and Responsibility: I, the undersigned, parent/guardian of the above named student, request that all procedures and administration of medication be performed as authorized by the Health Care Provider for my child in accordance with state laws and regulations. I understand medication may only be administered by licensed health professionals, and trained unlicensed personnel, according to state laws and regulations.

I agree to:
1. Notify the school nurse if there are any changes in my child's medical condition and treatment plan.
2. Maintain current phone numbers with the school nurse and school office in case 911 is called.
3. Provide the necessary medication, supplies, and equipment for my child's treatment while at school.

Parent /Guardian Authorization for School Staff to Communicate Health Information
I authorize the District's designees, including District medical professionals and UAPs, to share/obtain my child's health related information with the medical health professional or health care provider identified above to plan, implement or clarify actions necessary in the administration of school related health services such as but not limited to: emergency care, care for any documented diagnosis, and medical treatments. By signing this Authorization, I readily acknowledge that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by designees authorized herein and the person(s) with whom they communicate.

_____ **Parent/Guardian initials**

☐ **Yes** ☐ **No** **I give permission for my child to carry his/her inhaler, in accordance with physician's instructions above**

_____ _____
Parent/Guardian's Signature Date

Responsabilidad de Padre/Tutor: Yo, el abajo firmante, padre o tutor del estudiante nombrado arriba, solicita que sea realizado todos los procedimientos y la administración de medicamento según lo autorizado por el proveedor de salud de mi hijo de acuerdo con las leyes y reglamentos estatales. Entiendo que el medicamento sólo puede ser administrado por profesionales de salud licenciados y personal sin licencia que ha sido entrenado conforme a las leyes y reglas estatales.

Estoy de acuerdo en:
1. Notificar a la enfermera si hay algún cambio en la condición médica de mi hijo y/o el plan de tratamiento.
2. Mantener los números de teléfono actuales con la enfermera o la oficina escolar en caso de que se llama al 911.
3. Proporcionar el medicamento, suministros y equipos necesarios para el tratamiento de mi hijo/a en la escuela.

Autorización del padre de familia/tutor para que el Personal Escolar Comunique los Datos Médicos
Autorizo a los representantes del Distrito, incluyendo los profesionales médicos y UAPs del Distrito, a compartir con el profesional médico o proveedor de salud mencionado en la parte superior a obtener datos médicos de mi hijo/a a fin de planificar, implementar o aclarar las acciones necesarias en la administración de servicios escolares relacionados con la salud, que incluyen pero no se limitan a: atención de urgencia, cuidado para cualquier diagnóstico, o tratamientos médicos. Al firmar esta Autorización reconozco que la información usada o divulgada referente a los Datos Médicos personales e Identificables de mi hijo/a puede ser sujeto a re-divulgación por el personal autorizado y a las personas cual ellos se comuniquen.

_____ Iniciales del Padre/Tutor

☐ **Si** ☐ **No** **Doy permiso para que mi hijo/a cargue su inhalador, de acuerdo con las instrucciones del médico delineadas arriba.**

_____ _____
Firma de Padre o Tutor Fecha