ASTHMA ACTION PLAN

For: ______________________ Doctor: ______________________ Date: ______________

Doctor's Phone Number: ______________ Hospital/Emergency Department Phone Number: ______________

GREEN ZONE

DOING WELL

- No cough, wheeze, chest tightness, or shortness of breath during the day or night
- Can do usual activities

And, if a peak flow meter is used,

Peak flow: more than ______________
(80 percent or more of my best peak flow)

My best peak flow is: ______________

Daily Medications

Medicine	**How much to take**	**When to take it**
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________

Before exercise	❑ ______________	❑ 2 or ❑ 4 puffs	5 minutes before exercise

YELLOW ZONE

ASTHMA IS GETTING WORSE

- Cough, wheeze, chest tightness, or shortness of breath, or
- Waking at night due to asthma, or
- Can do some, but not all, usual activities

-Or-

Peak flow: __________ to __________
(50 to 79 percent of my best peak flow)

1st **Add: quick-relief medicine—and keep taking your GREEN ZONE medicine.**

______________ (quick-relief medicine) __________ Number of puffs **or** ❑ Nebulizer, once Can repeat every _____ minutes up to maximum of _____ doses

2nd **If your symptoms (and peak flow, if used) return to GREEN ZONE after 1 hour of above treatment:**

❑ Continue monitoring to be sure you stay in the green zone.

-Or-

If your symptoms (and peak flow, if used) do not return to GREEN ZONE after 1 hour of above treatment:

❑ Take: ______________ (quick-relief medicine) __________ Number of puffs **or** ❑ Nebulizer

❑ Add: ______________ (oral steroid) mg per day For ______ (3–10) days

❑ Call the doctor ❑ before/ ❑ within______ hours after taking the oral steroid.

RED ZONE

MEDICAL ALERT!

- Very short of breath, or
- Quick-relief medicines have not helped,
- Cannot do usual activities, or
- Symptoms are same or get worse after 24 hours in Yellow Zone

-Or-

Peak flow: less than ______________
(50 percent of my best peak flow)

Take this medicine:

❑ ______________ (quick-relief medicine) __________ Number of puffs **or** ❑ Nebulizer

❑ ______________ mg (oral steroid)

Then call your doctor NOW. Go to the hospital or call an ambulance if:

- You are still in the red zone after 15 minutes AND
- You have not reached your doctor.

DANGER SIGNS

- **Trouble walking and talking due to shortness of breath**
- **Lips or fingernails are blue**

- **Take ________ puffs of ______________ (quick relief medicine) AND**
- **Go to the hospital or call for an ambulance ______________ (phone) NOW!**

See the reverse side for things you can do to avoid your asthma triggers.

San Mateo Union High School District
Authorization for Medication(s) to be Taken During School Hours

Pursuant to Section 49423 and subdivision (b) of Section 49423.6 of the California Education Code, any pupil who is required to take, during the regular school day, prescribed medication may be assisted by a school nurse or other designated school personnel if both of the following conditions are met: (a) The pupil's authorized health care provider executes a written statement specifying, at a minimum, the medication the pupil is to take, the dosage, and the period of time during which the medication is to be take, as well as otherwise detailing (as may be necessary) the method, amount, and time schedule by which the medication is to be taken. (b) The pupil's parent or legal guardian provides a written statement initiating a request to have the medication administered to the pupil or to have the pupil otherwise assisted in the administration of the medication, in accordance with the authorized health care provider's written statement.
With the approval of the pupil's authorized health care provider and the approval of the pupil's parent or legal guardian, a local education agency may allow a pupil to carry medication and to self-administer the medication.

THE FOLLOWING SECTION IS TO BE COMPLETED BY THE PARENT: School Name____________________________

Student Name ____Gender______ Date of Birth______________________
Last First

____(_______)________________
Physician/Health Care Provider's Name Address Telephone

In regards to the medication authorized below by her/his physician/health care provider:

I request that my student be assisted in taking the medicine(s) at school by authorized persons: Yes_____ No_____

I request that my student be permitted to carry medication & self-medicate her/himself: Yes_____ No_____

I understand that the medication must be in the original pharmacy container, labeled with name of student, prescribing health care provider, and medication; date of the original prescription; strength and dose of medication; and directions for use. If medication is kept at school in the health office, it will be destroyed unless picked up within one week after the end of the school year or end of the medical order. I have read and signed the attached consent (reverse side) to allow designated school personnel to consult with my student's health care provider regarding medication questions. I understand that the medication may be discontinued with written parental request. As parent/guardian of the above-named student, I hereby indemnify and hold harmless from any demands, actions, suits, or liability of any nature or kind, any and all personnel, employees, and agents of the San Mateo Union High School District who may act pursuant to the instruction of my student's health care provider.

_____________ ____ (_______)_________________(______)_________________
Date **Signature of Parent/Guardian** **Home Phone** **Emergency**

THE FOLLOWING SECTION IS TO BE COMPLETED BY THE PHYSICIAN:

Diagnosis for which medication is given:____

Name of medication:____

Form: ___________________Dose & route: ____

If medicine is to be given DAILY, at what time(s):____

If medicine is to be given WHEN NEEDED, describe indications: ______________________________________

How soon can it be repeated?: ___________________________ Length of time this treatment is recommended: ___________________________

List significant side effects of medication: ____

In my opinion, this student shows the capability to carry and self-medicate the above medication: Yes_____ No_____

If necessary, this medication may be safely and appropriately administered by trained unlicensed school personnel: Yes_____ No_____ N/A_____

Date: ________________ **Signature of Authorized Health Care Provider:** ____

Health Care Provider Address Stamp (required):

SAN MATEO UNION HIGH SCHOOL DISTRICT
AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization. I have a right to receive a copy of this Authorization. Signing this Authorization may be required in order for this student to obtain appropriate services at school.

USE AND DISCLOSURE INFORMATION:

Patient/Student Name: ____

Last First MI Date of Birth

I, the undersigned, do hereby authorize (name of agency and/or health care providers):

(1) ______________________________ (2) ___________________________________

to provide health information from the above-named student's medical record to and from:

San Mateo Union High School District	**650 North Delaware St., San Mateo, CA 94401**
School District to which disclosure is made	Address/City and State/Zip Code
Sara Devaney, Health Services Manager	**650-558-2222 (Confidential Fax 650-762-0250)**
Contact person at School District	Area Code and Telephone Number

The disclosure of health information is required for the following purpose:

____

Requested information shall be limited to the following: □ All health information; or □ Disease-specific information as described:

____

DURATION: This authorization shall become effective immediately and shall remain in effect until ___________ (enter date) or for one year from the date of signature, if no date entered.

RESTRICTIONS: California law prohibits the School District from making further disclosure of my health information unless the School District obtains another authorization form from me or unless such disclosure is specifically required or permitted by law. I understand that the School District will protect this information as prescribed by the Family Educational Rights Privacy Act (FERPA) and state law and that the information becomes part of the student's education record. The information will be shared with individuals working at or with the School District for the purpose of providing safe, appropriate, and least restrictive educational settings and school health services and programs. *If you move to another School District, records will be transferred automatically to that School District.*

YOUR RIGHTS: I understand that I have the following rights with respect to this Authorization: *I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the health care agencies/persons listed above. My revocation will be effective upon receipt, but will not be effective to the extent that the School District or others have acted in reliance to this Authorization.*

APPROVAL: ______________________ ______________________ ____________

Printed Name Signature Date

______________________ ______________________

Relationship to Patient/Student Area Code and Telephone Number