

Asthma Action Plan

Students Name _____ DOB _____
 Parents Name _____ Phone _____

PARENT REQUEST/AUTHORIZATION FOR SERVICES

Education code 49423 authorizes that any pupil who is required to take, during the regular school day medication prescribed for him/her by a physician, may be assisted by the school nurse or other designated personnel if the school district receives (1) a written statement from such physician detailing the method, amount, and time schedules by which such medication is to be taken and (2) a written statement from the parent/guardian of the pupil indicating the desire that the school district assist the pupil in the matter set forth in the physician's statement. I request medication prescribed be administered to my student and agree to hold Hemet Unified School District, it's officers or employees harmless from all liability or claims which might arise out of these arrangements. I give my permission to contact the physician for consultation as needed. I understand that all medication will be destroyed at the end of the school year unless other arrangements are made and it is picked up by a parent or designee.

☐ Yes ☐ No

My child may carry and self-administer quick-relief medicine at school per Medical Provider's Authorization below required. In addition, student will notify the school Health Office whenever he/she takes the drug for the purposes of monitoring and record keeping. As Parent/Guardian, I agree to hold the School District harmless if any injury occurs to my child due to unsupervised use of prescribed medication at school per this request.

Signature of Parent/Guardian _____

Date _____

Asthma Severity: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Moderate Persistent
Asthma triggers: ☐ Exercise ☐ Pollens ☐ Illness ☐ Weather ☐ Animals ☐ Other: _____
☐ Odors ☐ Dust ☐ Mold/Moisture ☐ smoke ☐ Colds ☐ Stress/Emotions

Green Zone:

Doing Well

Go!

You have ALL of these
 • Breathing is easy
 • No cough or wheeze
 • Can work and play
 • Can sleep all night

☐ No Control Medications Required
☐ Maintenance Medication taken at Home
 For Symptoms with exercise, ADD
☐ _____ puff(s) 15 minutes before exercise
 Medication

Yellow Zone:

Getting Worse

Caution!

You have ANY of these
 • Hard to breathe
 • First sign of a cold
 • Cough or mild wheeze
 • Tight chest
 • Problems sleeping, working, or playing

☐ _____ puff(s) every _____ hours as needed
 OR Medication
☐ _____ Vial via nebulizer every _____ hours as needed
 Medication
☐ Other: _____

If you are in the Yellow Zone and symptoms are getting worse,
 Follow RED ZONE instructions.

Red Zone:

Emergency

Get Help Now!

You have ANY of these
 • Can't talk, eat, or walk well
 • Medicine is not helping
 • Breathing hard and fast
 • Blue lips and fingernails
 • Tired or lethargic
 • Ribs show
 • Nostrils flare

☐ _____ puff(s) every _____ minutes as needed
 OR Medication
☐ _____ Vial via nebulizer every _____ minutes as needed
 Medication
☐ Other: _____

Call 9-1-1 Immediately!

Self-Administration Guidelines (MUST be completed by Medical Provider):

Medication will be stored in the health office if neither box is checked.

- The above-named student may carry his/her medication on his/her person. The student has demonstrated knowledge of the correct dosage and administration and is sufficiently responsible to carry out my directions as instructed. In addition, he/she will notify the school Health Office whenever he/she takes the drug for the purposes of monitoring and record keeping.
- ☐ Student NOT approved to self-administer/self-carry the medicine(s) named above.

Licensed Physician's Name, Address, and Phone _____

Signature: _____

NPI Number: _____

Date: _____

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