CLINT INDEPENDENT SCHOOL DISTRICT
ASTHMA ACTION PLAN

Asthma and Allergy Foundation of America
aafa.org

STUDENTS NAME:	DOB:	ID #	TEACHER/GRADE:
MEDICAL DIAGNOSIS:	SCHOOL NAME:		
PARENT/GUARDIAN NAME:	PARENT/GUARDIAN PHONE #		
EMERGENCY CONTACT:	EMERGENCY CONTACT PHONE #		

ASTHMA SEVERITY:

☐ INTERMIDIATE ☐ MILD

☐ MODERATE ☐ SEVERE

TRIGGERS:

☐ COLDS ☐ SMOKE ☐ WEATHER
☐ EXERCISE ☐ DUST ☐ AIR
☐ POLLUTION ☐ ANIMALS ☐ FOOD
☐ OTHER:

EXERCISE: *PHYSICIAN RECOMMENDATIONS FOR AIR QUALITY ALERT DAYS*

☐ NO OUTDOOR EXERCISE
☐ LIMITED OUTDOOR ACTIVITY (NO RUNNING, SPRINTS, ETC)
☐ EXERCISE AS TOLERATED

GREEN ZONE:

PEAK FLOWS:

_____ TO _____

☐ NO CONTROL MEDICINES REQUIRED

MEDICINE	HOW MUCH	HOW OFTEN
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FOR ASTHMA WITH EXERCISE:

15 TO 20 MINUTES BEFORE EXERCISE

YELLOW ZONE:

PEAK FLOWS:

_____ TO _____

Tightness to chest, cough or mild wheeze, signs of upper respiratory illness, unable to exercise

☑ CONTINUE WITH GREEN ZONE MEDS AND ADD

MEDICINE	HOW MUCH	HOW OFTEN
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

COMMENTS OR SPECIAL INSTRUCTIONS:

RED ZONE:

PEAK FLOWS:

_____ TO _____

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_____%

MEDICINE	HOW MUCH	HOW OFTEN
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

☑ CALL 911

COMMENTS OR SPECIAL INSTRUCTIONS:

I, the signed physician, certify that the student has asthma and is capable of carrying and self-administering the above quick-relief asthma medication.
☐ Yes ☐ No

_____ _____
Physician Signature Date

_____
Office #

II. PARENT/ GUARDIAN SECTION

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.

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

Parent/ Guardian Signature: _____ Date: _____

II. SECCION DE PADRE O TUTOR

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.

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

Firma del Padre/Tutor: _____ Fecha: _____