

Asthma Action Plan

Asthma Action Plan (includes authorization for asthma medications at schools)

Child's Name: _____ Age: _____ Birthdate: _____ Grade: _____ School Year: 20____/20____

Parent Information:

Name of School: _____ Principal: _____ Teacher: _____ Room # _____

The following is to be completed by the PHYSICIAN:

A. Rescue medications (e.g., Albuterol; meds to give for peak flow <80% or other symptoms)

MED NAME	MDI/ORAL/NEB	DOSAGE OR NUMBER OF PUFFS
1.		
2.		

B. Routine medications (whether given at school or at home):

MED NAME	MDI/ORAL/NEB	DOSAGE OR NUMBER OF PUFFS
1.		
2.		

C. Medications before PE, exertion:

MED NAME	MDI/ORAL/NEB	DOSAGE OR NUMBER OF PUFFS
1.		
2.		

Peak Flow: Write patient's 'personal best' peak flow reading under the 100% box (below). Multiply by .8 and .5 respectively to define the Green, Yellow, and Red Zones:

100%	GREEN ZONE	80%	YELLOW ZONE TAKE RESCUE MEDS	50%	RED ZONE TAKE RESCUE MEDS & BEGIN EMERGENCY PLAN

Circle Triggers:

tobacco	car exhaust	cleansers
pesticide	perfume	exercise
animals	mold	other: _____
birds	cockroaches	
dust	cold air	

For Medications at School:

1. When taking oral medications, all students come to office to be supervised.
For inhaled medications, choose one of three options:
Assist student with meds in office.
Observe/remind; do not assist.
Student may carry own medication, if responsible.
2. Does doctor want to be contacted by school when symptoms interfere with student attendance or physical education participation? Yes No

Emergency Plan at School: School staff will give rescue medication, contact parent/guardian and/or seek emergency, care (dial 911) if the student has any of the following:

- **No improvement 15-20 minutes AFTER initial treatment with rescue medication**
- **Trouble walking, talking, or stops playing**
- **Peak flow is < 50% of usual best**
- **Breathing: chest/neck muscle retract, hunched, blue color**

Physician's[†] Name (print): _____

Signature: _____ Date: _____

Office Address: _____ Office Telephone #: _____

THE FOLLOWING IS TO BE COMPLETED BY THE PARENT OR GUARDIAN REQUESTING MEDICATION IN SCHOOL:

- **An adult must deliver the medication and this completed form to the school.**
- **Renew this form annually or earlier if doctor has put a time limit on the prescription.**

I request that the school nurse or other principal-designated person administer medications as directed by the physician (above). I authorize school health professional to communicate with prescribing physician if I am notified and if there are inquiries regarding school asthma management. I agree to save and hold the district, its officers, employees or agents, harmless from all liability, suits or claims, of whatever nature or kind, which might arise as a result of administering the medication in accord with this request.

Parent's/ Guardian's Signature: _____ Date: _____

Home Telephone Number: _____

Work Telephone Number: _____

Cellular Telephone Number: _____

Emergency Telephone Number(s) / Names of contact: _____

[†] includes nurse practitioner or other healthcare provider as long as there is authority to prescribe.
Source: Sample Asthma Action Plan; SCHOOL HEALTH USA; University of California at San Diego