San Diego Unified SCHOOL DISTRICT

Nursing &Wellness

# ASTHMA ACTION PLAN

Student Name: ______________________ Date of birth: ________________ Grade: ______

School: __________________________ Phone #: ____________ Fax #: ____________

**The following is to be completed by the PHYSICIAN:**

1. **Asthma Severity (check one):** ☐ Mild Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent
2. **Medications (at school AND home):**

| Medication | Route | Dosage | Frequency |
|---|---|---|---|
| *A. QUICK-RELIEF* | | | |
| 1. | | | |
| 2. | | | |
| *B. ROUTINE* (e.g. anti-inflammatory) | | | |
| 1. | | | |
| 2. | | | |
| *C. BEFORE P.E. Exertion* | | | |
| 1. | | | |

3. **For Student on Inhaled Medication:** ☐ assist student with medication in office ☐ remind student to take medication
   ☐ **may carry own medication, if responsible**

4. **Check Known Triggers:** ☐ tobacco ☐ pesticide ☐ animals ☐ birds ☐ dust ☐ cleansers ☐ car exhaust ☐ perfume ☐ mold ☐ cockroach ☐ cold air ☐ cleanser ☐ exercise other: ______________________

5. **Peak Flow:** Write student's 'personal best' peak flow reading under the 100% box (below); multiply by 0.8 and 0.5 respectively

| 100% | Green Zone | 80% | Yellow Zone | 50% | Red Zone |
|---|---|---|---|---|---|
| Peak Flow # = ______ | No Symptoms | Peak Flow # = ______ | **Starting to cough, wheeze or feel short of breath.** Action for home, school: Give 'Quick-Relief' med; notify parent. Action for Parent/MD: Increase controller dose ______ | Peak Flow # = ______ | **Cough, short of breath, trouble walking or talking** Action for home or school: Take Quick-Relief Meds; • If student improves to 'yellow zone' send student to doctor or contact doctor. • If student stays in 'red zone' begin Emergency Plan. |

**School Emergency Plan:** If student has: a) No improvement 15 – 20 minutes AFTER initial treatment with quick-relief medication, or
b) Peak flow is < 50% of usual best, or
c) Trouble walking or talking, or
d) Chest/neck muscle retract with breaths, hunched, or blue color

Then: 1. Give quick-relief medication; Repeat in 20 minutes if help has not arrived; 2. Seek emergency care (911); 3. Contact parent
Students with symptoms who need to use "quick-relief" meds may frequently need change in routine "controller" medications. Schools must be sure parent is aware of each occasion when student had symptoms and required medication.

**Physician's Name (print):** ____________________ **Signature:** ____________________ **Date:** ________

**License No.:** ____________ **NPI #:** ____________ **Office Telephone #:** ____________ **Office Fax #:** ____________

I authorize the school nurse, or other appropriately assigned school staff, to administer the medication/perform the procedure, as prescribed here in by the authorized health care provider. I will notify the school immediately and submit a new form, if there are any changes in the medication, procedure or the prescribing physician. I understand that school health staff are obliged by law to clarify issues associated with this order with the prescribing provider as necessary.

**Parent/Guardian Signature:** ______________________________ **Date:** ________________

**School Nurse Signature:** ______________________________ **Date:** ________________