CHULA VISTA ELEMENTARY SCHOOL DISTRICT

Asthma Action Plan

Attach child's

Name:	DOB:	Weight: (lbs or kg)
Date of Plan:	Age:	
Allergies:		

The following is to be completed by the PHYSICIAN:

1. Asthma severity: ☐ intermittent ☐ mild persistent ☐ moderate persistent ☐ severe persistent
2. Medications (at school AND home):

A. QUICK-RELIEF or "Rescue" Medication Name 1.	MDI, oral, neb?	Dosage or No. of Puffs
2.		
B. ROUTINE Med Name (eg anti-inflammatory) 1.	MDI, oral, neb?	Dosage or No. of Puffs Time of day
2.		
C. BEFORE PE, Exertion: Medication Name 1.	MDI, oral, neb?	Dosage or No. of Puffs
2.		

3. For student on inhaled medication (all students must go to health office for oral medications)
   ___ Assist student with medication ___ Remind student to take medication ___ May carry own medication, if responsible
4. List Known Triggers: _____
5. Peak Flow: Write patient's 'personal best' peak flow reading under the 100% box (below); Multiply by .8 and .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.** *At home or school:* - *Give Quick Relief' Med* - *Parent/MD: Increase controller dose*_____	Peak flow = _____	**Cough, short of breath, trouble walking/talking** *At home or school:* *Take Rescue Meds;* - *If student improves to 'yellow zone', send student to doctor or contact doctor.* - *If student stays in 'red zone', begin Emergency Plan.*

Emergency Plan at School: If student has: **a)** no improvement 15-20 minutes **AFTER** initial treatment with rescue 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 rescue meds; repeat in 20 min if help not arrived; **2.** seek emergency care (911); **3.** contact parent. **In yellow or red zone?** Students who need to use 'rescue meds' frequently may need change in routine 'controller' medication.

Physician's Name (print) _____ Signature _____ Date _____

License# _____ Office Address _____ Office Ph# _____

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.
- This form must be completed again by the doctor every school year (or more often if doctor put a time limit on the prescription).

I request that the school nurse or other designated person administer medications as directed by the physician (above). I authorize school health professional to communicate with the prescribing physician when the school or physician wants more information about school asthma symptoms or management.

Parent's/Guardian's Signature _____ Date _____

Emergency Contact Name/Ph# _____