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% Peak Flow # = _____	**Green Zone** No Symptoms	**80%** Peak Flow # = _____	**Yellow Zone** **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 _____	**50%** Peak Flow # = _____	**Red Zone** **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:** _____