

DAVILA DAY SCHOOL

Asthma Action Plan

Child's Name: _____ Birthdate: ___ / ___ / ___ Grade: ___ Teacher: _____

The following is to be completed by the PHYSICIAN:

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

A. <i>QUICK-RELIEF</i> or "Rescue" Medication Name: 1. _____ 2. _____	MDI, oral, neb? _____ _____	Dosage or # of Puffs _____ _____
B. <i>ROUTINE</i> Med Name (eg anti-inflammatory) 1. _____ 2. _____	MDI, oral, neb? _____ _____	Dosage or # of Puffs Time of Day _____ _____
C. <i>BEFORE PE, Exertion:</i> Medication Name: 1. _____ 2. _____	MDI, oral, neb? _____ _____	Dosage or # of Puffs _____ _____

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 medications, if responsible.

4. **Circle Known Triggers:** tobacco pesticide animals dust birds cleansers car exhaust perfume mold cockroach
 cold air exercise Other: _____

5. Peak Flow: Write patient's 'personal best' peak flow reading under the 100% box (below); Multiply by .8 & .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 <i>At home/school: Give 'Quick Relief' med; Notify parent</i> <i>Parent/MD: Increase controller dose _____</i>	Peak flow= _____	Cough, short of breath, trouble walking or talking <i>At home/school:</i> <i>Take Rescue Meds:</i> <i>-If student improves to 'yellow zone', send student to doctor or contact doctor</i> <i>-if student stays in 'red zone', begin Emergency Plan.</i>

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 with symptoms who need to use 'rescue meds' frequently may need change in routine 'controller' medication. Schools must be sure parent is aware of each occasion when student had symptoms and required medication.

Physician's † Name (print) _____ License# _____ Signature _____ Date _____

Office Address: _____ Office Telephone #: _____

†Includes nurse practitioner or other health care provider as long as there is authority to prescribe.

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 will be completed again by the doctor every school year (or more often if doctor has 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, if I am notified, when the school or physician want more information about school asthma symptoms or management.

Parent/Guardian's Signature: _____ Date: _____ Home Phone Number: _____

Emergency Contact: _____ Phone Number: _____

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Lo ue sigue debe ser terminando por el PADRE O GUARDA que pide la medicación en escuela:

- Un adulto debe entregar la medicación y este llenada el formulario a la esuela
- Será llenada el formulario otra vez por el doctor cada año escolar (o más a menudo si el doctor ha puesto un limite de tiempo en la prescripción).

Pido que la enfermera de la escuela o la persona señalada administer medicaciones según lo dirigido por el medico (arriba). Autorizo al professional de salud de la escuela a continuar con el medico que prescribe, si me notifican, cuando la escuela o el medico quiere más información sobre sintomas o la gerencia del asma de la escuela.

Firma del Padre/de Guarda: _____ Fecha: _____ Numero de Teléfono: _____

Contacto de la Emergencia: _____ Numero de Teléfono: _____

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