CHULA VISTA ELEMENTARY SCHOOL DISTRICT

84 East "J" Street • Chula Vista, CA 91910 • (619) 425-9600

Asthma Action Plan

Child's Name:_____ Birthdate:_____ Grade: _____ School:_____

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

3. For student on inhaled medication (all students must go to health office for oral medications)
__ Assist student with medication in office; __ Remind student to take medication; __ May carry own medication, if responsible

4. Circle Known Triggers: tobacco, pesticide, animals, birds, dust, 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 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, school: Give 'Quick-Relief' Med; Notify parent* *Parent/MD: Increase controller dose_____*	Peak flow = _____	**Cough, short of breath, trouble walking or 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 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's/Guardian's Signature_____ Date: _____ Home Telephone Number___ _____

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