SWEETWATER
UNION HIGH SCHOOL DISTRICT

ASTHMA ACTION PLAN

Student's Name: _____ Date of Birth: _____ Grade: _____

School: Bonita Vista High School Phone #: (619) Fax #: (619) 482-9356

The following is to be completed by the PHYSICIAN:

1. **Asthma Severity (circle 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. **Circle 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.

In yellow or red zone? 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: _____

Office Telephone #: _____ **Office Fax #:** _____

The following is to be completed by the PARENT/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 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. I agree to save and hold the district, its officers, employees or agents, harmless from all liability, suits or claims, of whatever nature or kind, which might arise as a result of administering the medication in accord with this request

Parent/Guardian Signature: _____ **Date:** _____

School Nurse Signature: _____ **Date:** _____