Fresno Unified School District

My Asthma Action Plan

Student Name _____ Date of Birth _____ ID # _____

School _____ School Phone # _____

Parent/Guardian Name _____ Parent/Guardian Phone # _____

Health Care Provider Name _____ Health Care Provider Phone # _____

Attention Parent/Guardian/School Personnel: ANY student with asthma (any severity) can have a SEVERE asthma attack.

Asthma is triggered by: ☐ Exercise ☐ Cold Air ☐ Animal Dander ☐ Strong Odors ☐ Grass/Pollen ☐ Colds/Flu ☐ Mold ☐ Other _____

Controller Medicines	How Much to Take	How Often	Other Instuctions
		_____ time(s) per day EVERY DAY!	☐ Gargle or rinse mouth after use
		_____ time(s) per day EVERY DAY!	

➢ **If student does not have any medication at school, follow the emergency instructions on the back.**

SPECIAL INSTRUCTIONS WHEN I AM ● *doing well,* ○ *getting worse,* ● *having a medical alert.*

GREEN ZONE

I Feel Good

- Breathing is good, and
- No cough, wheeze, chest tightness, or shortness of breath during the day or night, and
- Can work or play as normal.

Peak Flow (for ages 5 and up):
_____ to _____ (80% - 100% of personal best)

Personal Best Peak Flow is _____

PREVENT asthma symptoms every day:

☐ Take my controller medicines (above) every day

☐ Before exercise, take _____ puff(s) of _____ with spacer (if available) 10 minutes before exercise

YELLOW ZONE

I Don't Feel Good

- Cough, wheeze, chest tightness, shortness of breath, or
- Can do some, but not all usual activities.
- Waking at night due to asthma symptoms.
- Watch for ***Red Zone*** symptoms.

Peak Flow (for ages 5 and up):
_____ to _____ (50% to 79% of personal best)

CAUTION, Continue taking every day controller medicines, AND:

Begin QUICK RELIEF medication right NOW

- Take _____ puffs of _____ with spacer (if available). Wait 15 - 20 minutes. If symptoms are not better, repeat the above dose and wait another 15 minutes.
- If symptoms return to ***GREEN ZONE*** wait for 15 minutes.
- If symptoms remain in the ***Green Zone***, return to class and continue using quick relief medicine _____ puffs every _____ hours as needed.

➢ If ***NOT*** back in the ***Green Zone*** after the second dose of medicine, ***GO TO THE RED ZONE***

RED ZONE

Medical Alert

- Severe chest tightness, or
- Very short of breath or uncontrolled cough, or
- Nose opens wide or ribs show with breath, or
- Quick relief medicine has not helped, or
- Trouble talking or walking, or
- Blue lips or fingernails, or drowsy or confused

Peak Flow (ages 5 and up) under _____ (50% of personal best)

EMERGENCY! **Get Help! Do not leave student alone!**

Take ☐ 4 or ☐ 6 puffs of _____ with spacer (if available).

Repeat every 10 - 15 minutes until paramedics arrive.

➢ **Call 911 immediately and call Parent/Guardian**

Health Care Provider: My signature provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations.

Student may carry and self-administer asthma medications: ☐ **Yes** ☐ **No**

Print Provider Name/Credentials: _____ Signature _____ Date _____

This authorization is valid for one year from signature date.

Parent Request and Authorization: I request that the school assist my child with the above asthma medication(s) and the Asthma Action Plan as ordered by the health care provider in accordance with state laws and regulations. I understand that the medication must have a pharmacy label with the name of the student and the health care provider. I give permission for the school nurse to communicate with the health care provider on matters related to this Asthma Action Plan.

My child may carry and self-administer asthma medications: ☐ **Yes** ☐ **No**

Print Parent/Guardian Name: _____ Signature _____ Date _____

School Nurse: Has reviewed this action plan with: **Student** _____ **Parent** _____ **Office Staff** _____ **PE Teacher** _____

Adapted with permission from Regional Asthma Management and Prevention (RAMP), a program of the Public Health Institute, for use by Fresno Unified School District, Health Services & approved by FUSD Medical Advisory Committee, 11/2009.
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Fresno Unified School District

Medication at School Form

To be renewed annually (at least once each school year) and whenever changes in medication or authorized health care provider occur.

Student Name: _____ Date of Birth: _____
Last *First* *M.I.*

Student ID#: _____ School: _____ Grade/Room #: _____/_____

TO BE COMPLETED BY AUTHORIZED HEALTH CARE PROVIDER

Diagnosis or Reason for Medication during the school day: _____

If Rx is for an EMERGENCY SEIZURE MED – Do not list here. Please use reverse (or pg 2) of this form.

Name of Medication	*Dose and Frequency*	*Route*	*Time(s) to be given at school*

Possible **side effects** or other serious considerations regarding medication(s): _____

FOR **AUTO-INJECTOR EPINEPHRINE (EpiPen):**

Student is allergic to: _____

Student may carry EpiPen and self-administer ☐ Yes ☐ No (If yes, check statement below)

FOR **ASTHMA INHALERS:**

Student may carry asthma inhaler and self-administer ☐ Yes ☐ No (If yes, check statement below)

Does student need the prescribed medication _____ minutes before physical activity or sports? ☐ Yes ☐ No

☐ ***I have instructed the student in the proper method to use his/her*** ☐ ***asthma inhaler and/or*** ☐ ***EpiPen***
and in my opinion the student is competent to safely self-administer the medication at school.

_____ **Date:** _____
Health Care Provider Signature

_____ **Phone:** _____
Health Care Provider Name / Address (Please Print)

PARENT REQUEST AND AUTHORIZATION:

I request that the school nurse or designated school personnel assist my child with medication as ordered by the health care provider. I give permission for the school nurse to communicate with the health care provider on matters related to this medication. I will notify the school nurse of any changes in medication, health status, or authorized health care provider and will provide a new medication order form. I understand I may submit a written statement to withdraw my consent for administration of medication at school at any time.

I understand that the school must receive the medication in a container with a pharmacy label that indicates name of student, health care provider's name, medication, dose, route, and time to administer (over-the-counter medication must be in the original container). I understand that the medication must be delivered to the school by the parent, guardian, or adult designee.

I understand that my child may only take medication at school (including over-the-counter) if the school has received ALL of the following: a) Current California-authorized health care provider order, b) Parent/ guardian signature, and c) Properly labeled medication.

Parent Statement for Emergency Seizure Medications: I understand emergency seizure medication at school may only be administered by licensed health professionals, parent, or parent designee according to state laws and regulations.

1. I will notify the school nurse if the emergency seizure medication was administered to my child within 12 hours of child attending school.
2. I will notify the school nurse with any change in my child's seizure activity.
3. I will notify the school nurse at least 2 weeks in advance if my child will be attending a field trip, including overnight camp or trip. I understand physician clearance or new medication order may be required.
4. I will maintain current phone numbers with school nurse and school office in case 911 is called.
5. I will provide the necessary medication, supplies, and equipment.

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____