

# FORT BEND INDEPENDENT SCHOOL DISTRICT

## School Health Services

### ASTHMA ACTION PLAN

Student's Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Grade: \_\_\_\_ School: \_\_\_\_\_

#### 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** at home:

A. "QUICK-RELIEF" - Medication Name	MDI—Oral—Neb	Dosage OR Number of Puffs	
1.	<input type="checkbox"/> MDI <input type="checkbox"/> Oral <input type="checkbox"/> Neb		
2.	<input type="checkbox"/> MDI <input type="checkbox"/> Oral <input type="checkbox"/> Neb		
B. ROUTINE - Medication Name (e.g. anti-inflammatory)	MDI—Oral—Neb	Dosage OR Number of Puffs	Time of Day
1.	<input type="checkbox"/> MDI <input type="checkbox"/> Oral <input type="checkbox"/> Neb		
2.	<input type="checkbox"/> MDI <input type="checkbox"/> Oral <input type="checkbox"/> Neb		
	<input type="checkbox"/> MDI <input type="checkbox"/> Oral <input type="checkbox"/> Neb		
C. BEFORE P.E./EXERTION - Medication Name	MDI—Oral—Neb	Dosage OR Number of Puffs	
1.	<input type="checkbox"/> MDI <input type="checkbox"/> Oral <input type="checkbox"/> Neb		
2.	<input type="checkbox"/> MDI <input type="checkbox"/> Oral <input type="checkbox"/> Neb		

3. Check Known Triggers:    ☐ Tobacco    ☐ Pesticide    ☐ Animal    ☐ Bird    ☐ Dust    ☐ Cleaner    ☐ Car Exhaust    ☐ Perfume  
    ☐ Mold    ☐ Cockroach    ☐ Cold Air    ☐ Exercise    ☐ Other (please list) \_\_\_\_\_

4. Peak Flow: Write patient's 'personal best' peak flow reading under the 100% box (below). Multiple by .8 and .5, respectively.

100% GREEN ZONE Peak Flow =	80% YELLOW ZONE Peak flow =	50% RED ZONE Peak flow =
No Symptoms	<b>Starting to cough, wheeze or feel short of breath</b> <u>ACTION FOR HOME OR SCHOOL:</u> a. Give "Quick-Relief" Medication b. Notify Parent  <u>ACTION FOR PARENT/MD:</u> Increase controller dose to: _____	<b>Cough, short of breath, trouble walking/talking</b> <u>ACTION FOR HOME OR SCHOOL:</u> • Take "Quick-Relief" Medication • If student improves to "yellow zone" send student to doctor or contact doctor • If student stays in "red zone" begin Emergency Plan
If student has ... (a) No improvement 15-20 minutes <b>AFTER</b> 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 <b>THEN</b> 1. Give "Quick-Relief" medication; Repeat in 20 minutes if Help has not arrived; 2. Seek emergency care (911) 3. Contact parent		<b>IN YELLOW OR RED ZONE</b>  Students with symptoms who need to use "Quick-Relief" medication may frequently need a 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): \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Office Address: \_\_\_\_\_ Office Phone: \_\_\_\_\_

**I GIVE PERMISSION FOR SCHOOL NURSE TO CONSULT DR. \_\_\_\_\_ WITH QUESTIONS REGARDING THIS PLAN**

Parent/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Emergency Contact Name(s)/Number(s): \_\_\_\_\_