OAKLAND UNIFIED SCHOOL DISTRICT
Community Schools, Thriving Students

Asthma Action Plan

Student Name ______________________ Date of Birth __________ ID# __________
School ______________________ School Phone __________
Parent/Guardian Name ______________________ Parent/Guardian Phone __________
Emergency Contact Name ______________________ Emergency Contact Phone __________
Healthcare 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 at home	How Much to Take	How Often	Other instructions
		______ time(s) per day EVERY DAY!	Gargle or rinse mouth after use

▶ If student does not have any medication at school, notify parent immediately. Call 911 if symptoms persist longer than 10 minutes.

SPECIAL INSTRUCTIONS: WHEN I AM ☺ doing well, 😐 getting worse, ☹ having a medical alert

I Feel Good (Green Zone)

- 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 age 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 at home as prescribed

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

I Don't Feel Good (Yellow Zone)

- Cough, wheeze, chest tightness, or 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 age 5 and up):
__________ to _________(50% - 79% of personal best)

***CAUTION*, continue taking every day controller medicines at home, 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**

Medical Alert (Red Zone)

- 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 (for age 5 and up) under ______50% of personal best)

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

Take ☐ 4 or ☐ 6 puff 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 order. I understand that all procedures will be implemented in accordance with state laws and regulations.

Student 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 healthcare provider on matters related to this Asthma Action Plan.

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

Print Parent Name: ____________________ Signature ____________________ Date __________

Adapted with permission from Regional Asthma Management and Prevention (RAMP), a program of the Public Health Institute, for use by Oakland Unified School District, Health Services

School Nurse: ____________________ Signature ____________________ Date __________