OAKLAND UNIFIED SCHOOL DISTRICT

*Community Schools, Thriving Students*

# 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 Oakland Unified School District, Health Services.