School Information

Asthma Action Plan for Schools and Families

Health Care Provider Information

Last Name: _____ First Name: _____

Date of Birth (mm/dd/yyyy): _____ Medical Record #: _____

School Name: _____ School Contact Phone #: _____

Parent/Guardian Name: _____ Parent/Guardian Phone #: _____

Emergency Contact: _____ **Emergency Phone #:** _____

Health Care Provider Name: _____ Health Care Provider Phone #: _____

To be completed by health care provider: **Asthma Severity:** ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

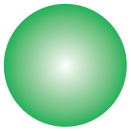
Attention Parent/Guardian/School Personnel: ANY student with asthma (of any severity) can have a severe asthma attack.

Asthma symptoms are triggered by: ☐ **Exercise** ☐ **Dust** ☐ **Animal dander** ☐ **Strong Odors or Fumes** ☐ **Mold** ☐ _____

Green Zone

Personal Best Peak Flow (PF) _____ Date: _____

Peak flow is between_____ (80% of personal best) and _____ (100% of personal best)



1. Take CONTROLLER medication(s) (at home) EVERY DAY:

Take _____ (Name of Medicine) inhaler_____ (How much) puffs _____ (How often) times/day.

Take _____ (Name of Medicine) inhaler _____ (How much) puffs _____ (How often) times/day.

If asthma is triggered by exercise (at school or home), take ☐ Albuterol or _____ (Name of Medicine) inhaler_____ (How much) puffs at least _____ minutes before exercise. Restrictions or activity limitations: _____

Yellow Zone-Caution! DO NOT LEAVE STUDENT ALONE!

Peak flow is between_____ (50% of personal best) and _____ (80% of personal best).

1. Begin QUICK RELIEF medication (at school or home) right NOW:

Take ☐ Albuterol or _____ (Name of Medicine) inhaler _____ (How much) puffs **OR** _____ (Name of Medicine) solution _____ (How much) ml by nebulizer.

- If symptoms are better or if the peak flow is improved within ☐ 15 minutes/_____minutes, THEN repeat QUICK RELIEF MEDICATION (as listed above in 1) every _____ (Number) hours for ____ (Number) days.
- If symptoms are **NOT** better or if the peak flow is **NOT** improved, go to Red Zone.

☐ **Attention School: Call Parent/Guardian when quick relief medication has been administered by student and/or staff.**

2. Attention Parent/Guardian (Home Instructions):

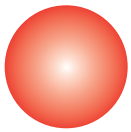
☐ Call your child's Health Care Provider

☐ Continue to take CONTROLLER medication (at home) everyday as written above in *Green Zone* instructions.

☐ Increase CONTROLLER medication:

Take _____ (Name of Medicine) inhaler_____ (How much) puffs _____ (How often) times/day for _____ (Number) days.

Red Zone-Medical Alert! Get Help! DO NOT LEAVE STUDENT ALONE! Peak flow is below_____ (50% of personal best).



1. Take QUICK RELIEF medication (at school or home) right NOW:

Take ☐ Albuterol or _____ (Name of Medicine) inhaler _____ (How much) puffs **OR** _____ (Name of Medicine) solution ____ (How much) ml by nebulizer and **REPEAT EVERY 20 MINUTES UNTIL PARAMEDICS ARRIVE!**

- **Call 9-1-1 immediately and call Parent/Guardian**

2. Attention Parent/Guardian (Home Instructions):

☐ Call your child's Health Care Provider. ☐ Continue CONTROLLER medication (at home):

Take _____ (Name of Medicine) inhaler_____ (How much) puffs _____ (How often) times/day for _____ (Number) days.

☐ And ADD_____ (Name of Medicine) _____ (How much) mg orally once daily for_____ (Number) days.

Authorization and Disclaimer from Parent/Guardian: I request that the school assist my child with the above asthma medications and the Asthma Action Plan in accordance with state laws and regulations. Yes ☐ No ☐

My child may carry and self-administer asthma medications and I agree to release the school district and school personnel from all claims of liability if my child suffers any adverse reactions from self-administration of asthma medications: Yes ☐ No ☐

_____ Parent/Guardian Signature _____ Date

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 ☐ (This authorization is for a maximum of one year from signature date.)

_____ Healthcare Provider Signature _____ Date

California Asthma Public Health Initiative, California Department of Health Services

Using Symptoms and/or Peak Flow to Know Your Zone

Green Zone

- ✔ No cough or wheeze at day or night.
- ✔ No chest tightness.

OR

- ✔ **Peak flow** is between_____ (80% of personal best) and _____ (100% of personal best).

Yellow Zone - Caution!

Any asthma symptoms:

- ✔ Cough or wheeze at day or night.
- ✔ Chest tightness.
- ✔ Problems playing.
- ✔ Waking at night with asthma symptoms.

OR

- ✔ **Peak flow** is between_____ (50% of personal best) and _____(80% of personal best).

Red Zone - Medical Alert!

Any asthma symptoms:

- ✔ Persistent cough or wheeze.
- ✔ Severe chest tightness.
- ✔ Can not walk, talk, or move well.
- ✔ Blue skin color around lips or nails.

OR

- ✔ **Peak flow is below**_____ (50% of personal best).

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Parent/Guardian Name: _____ Parent/Guardian Phone #: _____

Emergency Contact: _____ **Emergency Phone #:** _____

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Green Zone

Personal Best Peak Flow (PF) _____ Date: _____

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- ☐ **Attention School: Call Parent/Guardian when quick relief medication has been administered by student and/or staff.**

2. Attention Parent/Guardian (Home Instructions):

☐ Call your child's Health Care Provider

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☐ Increase CONTROLLER medication:

Take _____ (Name of Medicine) inhaler_____ (How much) puffs _____ (How often) times/day for _____ (Number) days.

Red Zone-Medical Alert! Get Help! DO NOT LEAVE STUDENT ALONE! Peak flow is below_____ (50% of personal best).

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_____ (Parent/Guardian Signature) _____ (Date)

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 ☐ (This authorization is for a maximum of one year from signature date.)

_____ (Healthcare Provider Signature) _____ (Date)

California Asthma Public Health Initiative, California Department of Health Services

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION TO SCHOOL DISTRICTS

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Federal laws (including HIPAA) concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

USE AND DISCLOSURE INFORMATION:

Patient/Student Name: _____ / _____
Last First MI Date of Birth

I, the undersigned, do hereby authorize (name of agency and/or health care providers):

(1) _____ (2) _____

to provide health information from the above-named child's medical record to and from:

_____ _____
School District to Which Disclosure is Made Address / City and State / Zip Code

_____ _____
Contact Person at School District Area Code and Telephone Number

The disclosure of health information is required for the following purpose:

_____

Requested information shall be limited to the following: ❑ All health information; **or**
❑ Disease-specific information as described:

_____

DURATION:
This authorization shall become effective immediately and shall remain in effect until _____ *(enter date)* or for one year from the date of signature, if no date entered.

RESTRICTIONS:
Law prohibits the Requestor from making further disclosure of my health information unless the Requestor obtains another authorization form from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS:
I understand that I have the following rights with respect to this Authorization: *I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the health care agencies/persons listed above. My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance to this Authorization.*

RE-DISCLOSURE:
I understand that the Requestor (School District) will protect this information as prescribed by the Family Equal Rights Protection Act (FERPA) and that the information becomes part of the student's educational record. The information will be shared with individuals working at or with the School District for the purpose of providing safe, appropriate, and least restrictive educational settings and school health services and programs.

I have a right to receive a copy of this Authorization. Signing this Authorization may be required in order for this student to obtain appropriate services in the educational setting.

APPROVAL: _____ _____ _____
Printed Name Signature Date

_____ _____
Relationship to Patient/Student Area Code and Telephone Number

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