




Student Name _____ Date of Birth _____ ID# _____
 School _____ School Phone _____
 Parent/Guardian Name _____ Parent/Guardian Phone _____
 Emergency Contact Name _____ Emergency Contact Phone _____
 Healthcare Provider Name _____ Healthcare 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)	PREVENT asthma symptoms every day:
<ul style="list-style-type: none"> 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) <p>Personal Best Peak Flow is _____</p> 	<ul style="list-style-type: none"> <input type="checkbox"/> Take my controller medicines (above) every day at home as prescribed <input type="checkbox"/> Before exercise, take _____ puff(s) of _____ with spacer (if available) 10 minutes before exercise
I Don't Feel Good (Yellow Zone)	CAUTION, continue taking every day controller medicines at home, AND:
<ul style="list-style-type: none"> Cough, wheeze, chest tightness, or shortness of breath, or can do some, but not all usual activities. Waking at night due to asthma symptoms. <p>Watch for Red Zone symptoms.</p> <ul style="list-style-type: none"> Peak Flow (for age 5 and up): _____ to _____ (50% - 79% of personal best) 	<p>Begin QUICK RELIEF medication right NOW</p> <ul style="list-style-type: none"> 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. <p>▶ If NOT back in the Green Zone after the second dose of medicine, GO TO THE RED ZONE</p>
Medical Alert (Red Zone)	EMERGENCY! Get help! Do not leave student alone!
<ul style="list-style-type: none"> 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 <p>Peak Flow (for age 5 and up) under _____ 50% of personal best)</p> 	<p>Take <input type="checkbox"/> 4 or <input type="checkbox"/> 6 puff of _____ with spacer (if available).</p> <p>Repeat every 10 – 15 minutes until paramedics arrive.</p> <p>▶ Call 911 immediately and call Parent/Guardian</p>

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 _____