FORT BEND INDEPENDENT SCHOOL DISTRICT School Health Services

ASTHMA ACTION PLAN

Student's Name: DOB		B:/_	_/ Grad	le: 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.		□ MDI □	Oral 🗖 Neb			
2.		□ MDI □	Oral 🗖 Neb			
B. ROUTINE - Medication Name (e.g. anti-inflammatory)		MDI—Oral—Neb		Dosage OR Number of Puffs	Time of Day	
1.		☐ MDI ☐ Oral ☐ Neb				
2.		☐ MDI ☐ Oral ☐ Neb				
		☐ MDI ☐ Oral ☐ Neb				
C. BEFORE P.E./EXERTION - Medication Name		MDI—0	ral—Neb	Dosage OR Number of Puffs		
1.		□ MDI □	Oral 🗖 Neb			
2.		□ MDI □	Oral 🗖 Neb			
 □ 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. 5. Pulse Oximetry: Provide pulse oximetry parameters if applicable 						
100% GREEN ZONE	80% YELLOW ZONE			50% RED ZONE		
Peak Flow = No Symptoms	Peak flow = SpO2 ≤% Starting to cough, wheeze or feel short of breath ACTION FOR HOME OR SCHOOL: a. Give "Quick-Relief" Medication b. Notify Parent ACTION FOR PARENT/MD: Increase controller dose to:		Cough, short ACTION FOR Take "Quick If student in or contact	Peak flow = SpO2 ≤% Cough, short of breath, trouble walking/talking ACTION FOR HOME OR SCHOOL: • 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				IN YELLOW OR RED ZONE		
 (a) No improvement 15-20 min medication, or (b) Peak Flow is <50% of usua (c) Trouble walking or talking, (d) Chest/Neck muscle retract THEN 		Students wit Relief' medi routine "con	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			
 Give "Quick-Relief" medic Seek emergency care (911) Contact parent 	Help has not arrive					
Physician's Name (print):		Signature:		Date:		
Office Address:		Office Phone:				
I give permission for Fort Bend ISD personnel to follow the Action Plan above and consult the MD with questions regarding the plan.						
Parent/Guardian's Signature:			Date:	Home Phone:		
Emergency Contact Name(s)/Numbe	sr(c)/·					