

FORT BEND INDEPENDENT SCHOOL DISTRICT
School Health Services
ASTHMA ACTION PLAN

Student's Name: _____ DOB: ____/____/____ Grade: ____ 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.	<input type="checkbox"/> MDI <input type="checkbox"/> Oral <input type="checkbox"/> Neb		
2.	<input type="checkbox"/> MDI <input type="checkbox"/> Oral <input type="checkbox"/> Neb		
B. ROUTINE - Medication Name <i>(e.g. anti-inflammatory)</i>	MDI—Oral—Neb	Dosage OR Number of Puffs	Time of Day
1.	<input type="checkbox"/> MDI <input type="checkbox"/> Oral <input type="checkbox"/> Neb		
2.	<input type="checkbox"/> MDI <input type="checkbox"/> Oral <input type="checkbox"/> Neb		
	<input type="checkbox"/> MDI <input type="checkbox"/> Oral <input type="checkbox"/> Neb		
C. BEFORE P.E./EXERTION - Medication Name	MDI—Oral—Neb	Dosage OR Number of Puffs	
1.	<input type="checkbox"/> MDI <input type="checkbox"/> Oral <input type="checkbox"/> Neb		
2.	<input type="checkbox"/> MDI <input type="checkbox"/> Oral <input type="checkbox"/> Neb		

For student on inhaled medication (all students must go to the Health Office for oral medications).

3. Check Known Triggers: Tobacco Pesticide Animal Bird Dust Cleaner Car Exhaust Perfume
 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 Peak Flow = _____	80% YELLOW ZONE Peak flow = _____ SpO2 ≤ _____ %	50% RED ZONE Peak flow = _____ SpO2 ≤ _____ %
No Symptoms	Starting to cough, wheeze or feel short of breath <u>ACTION FOR HOME OR SCHOOL:</u> a. Give "Quick-Relief" Medication b. Notify Parent <u>ACTION FOR PARENT/MD:</u> Increase controller dose to: _____	Cough, short of breath, trouble walking/talking <u>ACTION FOR HOME OR SCHOOL:</u> • 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 ... (a) No improvement 15-20 minutes AFTER initial treatment with "Quick-Relief" medication, or (b) Peak Flow is <50% of usual best, or (c) Trouble walking or talking, or (d) Chest/Neck muscle retract with breaths, hunched, or blue color <u>THEN</u> 1. Give "Quick-Relief" medication; Repeat in 20 minutes if Help has not arrived; 2. Seek emergency care (911) 3. Contact parent		IN YELLOW OR RED ZONE 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

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)/Number(s): _____