SCHOOL ASTHMA ACTION PLAN

Student Name:		
DOB:	ID:	
Severity Classification: □ Mild Intermittent □ Mild Persistent □ Moderate □ Severe		

BREATHING IS EASY:

- ☐ No cough
- ☐ No wheezing
- ☐ No shortness of breath

PEAK FLOW >

MAINTENANCE THERAPY

PRESCRIBED **maintenance medication** taken at home:

Med/dose/route/frequency:
Med/dose/route/frequency:

PRESCRIBED **controller medication** before activities/PE at school:

Med/dose/route:

FLARE-UP OF SYMPTOMS:

- ☐ **Coughing**
- ☐ **Wheezing**
- ☐ **Shortness of breath**
- ☐ **Tightness of chest**
- ☐ **Difficulty with activity**

PEAK FLOW BETWEEN
and

STEP UP THERAPY

PRESCRIBED **quick relief** medication:

Med/dose/route/frequency:

Expect symptoms to resolve within ______ minutes. If relieved, return to green zone, student may return to class. If symptoms are mild, but medication provides no relief, student should stay in office and parents should be contacted. If symptoms are moderate and cannot be controlled or if worsening of symptoms, proceed to red zone.

☐ **THIS STUDENT SELF MANAGES/CARRIES THEIR OWN RESCUE MEDICATION**

EMERGENCY:

- ☐ **BREATHING IS DIFFICULT**
- ☐ **CANNOT WALK OR TALK**
- ☐ **CHANGE IN LEVEL OF CONCIOUSNESS**

PEAK FLOW <

EMERGENCY TREATMENT

IMMEDIATELY BEGIN CPR AS NECESSARY, DO NOT LEAVE STUDENT, DELEGATE CALLS TO:

EMS: 911

PARENT:

SCHOOL NURSE: (503) 793-5651

Medical Provider:	Parent's signature acknowledges above information as the current medical plan for student, as agreed upon by provider and authorizes the school or school nurse to speak with the named provider or clinic, or release medication information to EMS in the event of an asthma related emergency. MD signature indicates review and agreement of plan. RN signature indicates review of plan. A MEDICATION ADMINISTRATION FORM MUST ALSO BE SIGNED.
Clinic:	
Phone:	

MD Signature (only required with medically complicated asthma)   Date

Parent Signature (required)   Date

School RN Signature (required)   Date