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.	❑ 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—Oral—Neb**	**Dosage OR Number of Puffs**	
1.	❑ MDI ❑ Oral ❑ Neb		
2.	❑ MDI ❑ Oral ❑ 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 =** No Symptoms	**80% YELLOW ZONE** **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: _____	**50% RED ZONE** **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 ... (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 **THEN** 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)/: _____

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