HEALTH SERVICES

Snowline Joint Unified School District
4075 Nielson Road
P.O. Box 296000, Phelan, CA 92329-6000

Office of the District School Nurse
(760) 868-5805 Phone
(760) 868-5806 Fax

ASTHMA ACTION PLAN

ATTENTION PARENT/GUARDIAN: ANY student with asthma (of any severity) can have a severe asthma attack.

STUDENT NAME: _____DOB: _____ GRADE: _____ DATE: _____

SCHOOL: _____ TEACHER/COUNSELOR: _____

GREEN ZONE: Personal Best Peak Flow (PF) is between: (100%)_____ (80%)_____
Symptoms are: Good breathing, no shortness of breath during the day or night, no cough, no chest tightness, able to exercise and do usual activities or _____

ACTION: 1. Use daily "Controller" medicine as prescribed:
Medication #1:

_____
Name Amount Times per day

Medication #2:

_____
Name Amount Times per day

_____ Exercise induced asthma take: _____
Medication name Amount Times per day

YELLOW ZONE: CAUTION!!! Asthma is getting worse. DO NOT LEAVE STUDENT ALONE.

Peak Flow (PF) is between: (80%)_____ (50%)_____

Symptoms are: Some coughing, wheezing, chest tightness, waking at night due to asthma symptoms, shortness of breath while resting, some activity restrictions or

_____

ACTION: 1. Use "Quick relief" medicine as prescribed NOW:
Medication #1:

_____
Name Amount How often

Medication #2: _____
Name Amount How often

Attention School Personnel: Call Parent/Guardian when "Quick Relief" medicine has been administered.

2. If symptoms are better and/or peak flow improves above 80% within 15 minutes, then repeat "Quick relief" medicine every _____hours for _____days
3. If symptoms are **NOT** better or peak flow does **NOT** improve after 30 minutes, go to **RED ZONE**.

RED ZONE: **MEDICAL ALERT!!!!! Get Help! DO NOT LEAVE STUDENT ALONE! CALL 911**

Peak Flow (PF) is below (50%) _____

Symptoms are: Wheezing or very diminished breathing sounds, very short of breath, difficulty walking or talking, moderate to severe activity restrictions, "Quick relief" medications ineffective, symptoms are the same or worse after 30 minutes in **Yellow Zone** or_____

ACTION: **1. RIGHT NOW: Use "Quick relief" medicine.**
2. CALL 911, parent/guardian, and district nurse.
3. STAY WITH STUDENT UNTIL PARAMEDICS ARRIVE.

OVER

Asthma Action Plan
(Continued)

All medication will automatically <u>discontinued</u> at the end of the school year. New orders are required each school year.

California Education Code section 49423* **provides that any pupil who is required to take, during the regular school day, medication prescribed for him by a physician, may be assisted by the school nurse or other designated school personnel if the school district receives (1) a written statement from such physician detailing the method, amount, and time schedules by which such medication is to be taken and (2) a written statement from the parent or guardian of the pupil indicating the desire that the school district assist the pupil in the matters set forth in the physician's statement.**

*California Education Code section 49423 (c): A pupil may be subject to disciplinary action pursuant to Section 48900 if that pupil uses an inhaler or auto-injectable epinephrine in a manner other than as prescribed.

Physician Signature: My signature provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. **This student has received this medication previously with no adverse side-effects.**

_____	_____	_____
Health Care Provider Signature	Phone number/ext.	Date

Parent Request for School-Assisted Administration of Medication

Release of Liability and Agreement to Indemnify and Hold School District Harmless (<u>must be completed</u>)
I hereby expressly release, hold harmless, and agree to indemnify and defend the **SNOWLINE** School District and its Governing Board members, officers, employees, agents, representatives, independent contractors and insurers (collectively referred to as the "District") from all claims and liability for any personal injuries, death or property damage that may be incurred by permitting the school to assist in the administration of my child's medication. This release, hold harmless and indemnification agreement shall remain in effect until the written notice to terminate the agreement is received and acknowledged in writing by the school principal or designee. I/we understand and agree that if I/we terminate this agreement, the school will no longer assist in administration of medication to my child.

I understand that school district regulations require student medication to be maintained in a secure place, under the direction of an adult employee of the school district, and not carried on the person of a student.

I hereby request that the staff of my child's school assist with administration of medication to my child during school hours as stated in the physician instructions. I also give permission to contact the physician for consultation as needed.

Signature of Parent or Guardian: _____ Date: _____ Phone: _____

For Carrying and Self-Administering Inhaled Medications: (not recommended in Elementary School)

☐ I have instructed _____in the proper way to use his/her medications. It is my professional opinion that _____ should be allowed to carry and use that medication by him/herself.

☐ It is my professional opinion that _____ should <u>NOT</u> carry his/her inhaled medication by him/herself.

_____	_____
Physician Signature	Date
_____	_____
Parent/Guardian Signature	Date