Manhattan Beach Unified School District

Symptom Based Asthma Action Plan for School – School Year _____

Student: _____DOB: _____Grade: _____ School: _____Phone/Fax:_____

Parent/Guardian:_____ Home# _____ Cell #_____

SYMPTOM GUIDELINES	ACTION FOR SCHOOL
GREEN ZONE: Good breathing, no shortness of breath during day or night, no cough, no chest tightness, able to exercise and do usual activities.	
YELLOW ZONE: Starting to cough, wheeze, feel short of breath, chest tightness, waking at night due to asthma symptoms, or having some activity restrictions	Give Quick Relief (Albuterol or Xopenex) medications If symptoms are relieved, student may return to class. If symptoms are NOT RELIEVED, repeat Quick Relief medications in 20 min. Notify Parent if symptoms are NOT relieved by medication after 15-20 min. If symptoms are still not improved, proceed to Red Zone Action.
RED ZONE: Repetitive, nonstop cough, trouble walking or talking, chest muscle retractions with breathing, hunched position, blue color, audible wheezing, very short of breath, difficulty doing things you normally do, symptoms not improved following treatment recommended in yellow zone.	Repeat Quick Relief medication now. **Call 9-1-1. Seek Emergency Care.** Contact parent/guardian and school nurse. Repeat Quick Relief medication(s) every 20 minutes until help arrives or until symptoms improve. Stay with student until paramedics arrive.

PHYSICIAN TO COMPLETE THIS SECTION:

MAINTENANCE MEDICATIONS TO BE USED AT HOME:_____

MEDICATIONS TO BE USED AT SCHOOL:

		Dosage Schedule (check off and/or fill in guidelines)			
Name/Form of medication (check off or list)	Dosage	Frequency Every _____ hrs	15 min before PE or sports	Daily @ what time	As needed (see zone recommendations below)
QUICK RELIEF MEDICATION ☐ Albuterol HFA Nebulizer solution					
QUICK RELIEF MEDICATION ☐ Xopenex HFA Nebulizer solution					
☐ STEROID:_____					

☐ A Spacer Device (such as an Aerochamber) is recommended for use with metered dose inhalers for ALL students.

☐ Student needs to have assistance with inhaled medication in Health Office.

☐ Student may self-carry and self-administer inhaler medication. (Middle School and High School Students only)

Known Triggers/check off: ☐Exercise ☐Dust ☐Poor Air Quality ☐Smoke ☐Strong Odors ☐Animal dander/birds ☐Pollen ☐Mold ☐Viral ☐Colds ☐ Cold Air ☐ Foods _____ ☐ Other _____

Additional physician instructions/comments: School to contact parent, parent to contact physician if child needs quick relief medication more than twice in one week (unless previously prescribed by physician)_____

_____ _____

Doctor/Healthcare Provider Signature Date

PARENT/GUARDIAN AUTHORIZATION: I have read and agree to this plan above. I authorize medications to be given as delineated above and agree to follow MBUSD medication policies. I authorize the school staff and my child's physician to share information about my child's health as needed.

Parent/Guardian Signature:_____ Date _____

MBUSD policy requires renewal of the Asthma Action Plan at the beginning of each school year.