Placentia Yorba Linda Unified School District
Asthma Action Plan

Name_____ **DOB**_____ **School** _____**Grade**___

Triggers (check all that apply)**:**
☐ Respiratory infections ☐ Exercise ☐ Pollen ☐ Dust ☐ Mold ☐ Cold air ☐ Weather changes

☐ Animals ☐ Food (list all): _____ ☐ Other: _____

Health care provider to complete remainder of this page:

Daily Controller Medicine given at home (Please list): _____

Good Control (if applicable, Peak flow > _____): Breathing is good No cough or wheeze Activity easily tolerated	**Plan:** ▪ Allow activity as tolerated ▪ Use inhaler if needed before exercise/PE, as indicated in orders below
Acute Asthma Attack **If student has any of these Signs or Symptoms:** **(If applicable, Peak flow ____ to _____)** Coughing Wheezing Short of breath, especially with activity Complaints of tightness in chest _____ **If symptoms don't improve or worsen**	**Plan:** ▪ Use inhaler as ordered below ▪ Stay with student / Reassure student ▪ Have student rest in most comfortable position until symptom free ▪ PE limitations: _____ _____ **Plan:** ▪ Notify school nurse and parents ▪ Repeat inhaler as ordered below
Severe/Prolonged Asthma Attack **If student has any of these Signs or Symptoms:** **(If applicable, Peak flow <_____):** Difficulty breathing, coughing, wheezing **with no relief from inhaler** Difficulty walking/talking due to asthma symptoms Turning blue, especially around lips or fingernails Neck/chest pulls in with breathing	**Plan:** ▪ Take inhaler as ordered below ▪ **CALL 911** ▪ Notify school nurse and parent

Inhaler (Brand) _____ Side Effects: _____ Other Instructions: (i.e.: before PE)_____ Inhaler should be brought on all field trips or sporting events	Dose _____ Route_____ Maximum doses per day: _____	Amount of time between doses_____ --- **If no relief**, repeat in _____ minutes X ___. ☐ Not applicable

It is of my professional opinion that this student should be permitted to carry/self administer this inhaler. This student has been instructed and demonstrates an understanding of proper usage. *Health Care Provider Initials* _____	Office Stamp

Authorized Health Care Provider Signature: _____ Phone: _____

Name (printed): _____ Date: _____

(Must include Page 2 and appropriate signatures.)

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Parent/Guardian Request for the Administration of Medication: Prescription and Non-Prescription

California Education Code Section, 49423 allows the school nurse or other designated non-medical school personnel to assist students who are required to take medication during the school day. This service is provided to enable the student to remain in school and to maintain, or improve his/her potential for education and learning.

I request that medication be administered to my child in accordance with our authorized health care provider written instructions. I understand that designated non-medical school personnel may assist in carrying out written orders under supervision of a qualified School Nurse. I will notify the school immediately and submit a new form if there are changes in medication, dosage, time of administration, and/or the prescribing authorized health care provider. I give permission for the school nurse to exchange medication-related information with the authorized health care provider. The school nurse may counsel appropriate school personnel regarding the medication and its possible effects.

Emergency medicine such as EpiPen or inhalers may be carried by the student when recommended by an authorized health care provider and parent. Back-up medication should be kept at school for emergency use. I release the district and school personnel from civil liability if my child suffers an adverse reaction as a result of self-administering medication.

Medicine must be delivered to school by parent/ guardian or other responsible adult and must be in original, labeled pharmacy container, written in English.

This request is valid for a maximum of one year.

I agree with the above Asthma Action Plan: _____ Date: _____
Parent Signature

Emergency Contact Name/Numbers:

Parent/guardian: _____Phone: _____ Cell: _____

School Nurse: _____ Phone: _____

Other Emergency Contacts:

Name/Relationship _____ Phone: _____

Name/Relationship _____ Phone: _____

Reviewed by
School Nurse _____ Date _____