Rocklin Unified School District

Health Services

www.RocklinUSD.org/Health

Asthma Action Plan

Student Name_____ DOB_____ Grade_____

According to your child's health records, he/she has asthma. Please complete the sections below and return it to school so we will have more complete information. ***ANY medication needed while at school requires a physician's order.***

1. Triggers that might start an asthma episode for this student:

☐ Exercise ☐ Animal Dander ☐ Respiratory Infections ☐ Cigarette smoke, strong odors
☐ Pollens ☐ Molds ☐ Temperature Changes ☐ Foods: _____
☐ Emotions (e.g. when upset) ☐ Irritants (e.g. chalk dust) ☐ Other: _____

2. Accommodations in the School Environment:

☐ Suggested environmental measures to control triggers at school _____
☐ Pre-Medications (prior to exercise, choir, band, etc.) _____
☐ Dietary Restrictions _____

3. Peak Flow Monitoring

☐ Do Not Monitor Peak Flow
☐ Monitor Peak Flow: Personal Best Peak Flow_____ Monitoring Times_____

Steps to Take During an Asthma Episode

1. Give emergency asthma medications as indicated below.

Medication	Dose/Frequency	Frequency	When to Administer
	☐ 1 puff ☐ 2 puffs ☐ 3 puffs* ☐ 4 puffs* ☐ Other*: _____	☐ every 2 hours* ☐ every 4 hours* ☐ every __ hours*	☐ Coughing ☐ Short of breath ☐ Wheezing ☐ Chest tightness ☐ Before exercise ☐ other:_____
	☐ 1 puff ☐ 2 puffs ☐ 3 puffs* ☐ 4 puffs* ☐ Other*: _____	☐ every 2 hours* ☐ every 4 hours* ☐ every __ hours*	☐ Coughing ☐ Short of breath ☐ Wheezing ☐ Chest tightness ☐ Before exercise ☐ other:_____

** If more than 2 puffs are given in a day the nurse and paren/guardiant shall be notified*

2. Call 911 to activate EMS if the student has ANY of the following symptoms:

- Lips or fingernails are blue or gray
- Student is too short of breath to walk, talk, or eat normally
- No relief from medication within 15-20 minutes with any of the following signs
  - Chest and neck pulling in with breathing
  - Student is hunching over
  - Student is struggling to breathe

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Student Name_____ **DOB**_____ **Grade**_____

AUTHORIZED CONSENT FOR MANAGEMENT OF ASTHMA AT SCHOOL

My signature below provides the authorization for the above written orders. I understand that all procedures will be implemented in accordance with CA state laws and regulations. In understand that specialized physical health care services may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization (may be faxed).

1. I have instructed _____in the proper use of his/her medications. It is my Professional opinion that he/she should be allowed to carry and administer the medication by him/herself.

2. It is my professional opinion that _____ **should not** carry or administer his/her medication by him/herself.

Physician Signature _____ Date _____

Physician Printed Name_____ **Stamp:**

Address_____

Telephone (_____)_____-_____

Parent Consent for Management of Asthma at School

I, the parent or guardian of the above named student, request that this School Asthma Action Plan be used to guide asthma care for my child. I agree to:

1. Provide necessary supplies and equipment.
2. Notify the nurse of any changes in the student's health status.
3. Notify the nurse and complete new consent for changes in orders from the student's health care provider.
4. Authorize the nurse to communicate with the primary care provider/specialist about asthma/allergy as needed.
5. I ACKNOWLEDGE IF MY STUDENT CARRIES AND ADMINISTERS HIS/HER OWN MEDICATION, IT MUST BE ON HIM/HER PERSON IN ORDER TO ATTEND A FIELD TRIP

Parent/Legal Guardian Signature_____ Date _____

Principal's Signature _____ Date _____

Nurse's Signature _____ Date _____