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	□ Cigarette smoke, strong odors	□ Respiratory Infections
□ Pollens	□ Temperature Changes	□ Foods_____	□ Emotions (e.g. when upset)
□ Molds	□ Irritants (e.g. chalk dust)	□ Other_____	

2. Control of the School Environment:

____ 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_____

****Immediate action is required when the student exhibits any of the following signs of respiratory distress. Always treat symptoms even if a peak flow meter is not available.**

Severe cough	Shortness of Breath	Sucking in of the chest wall	Difficulty walking from breathing
Chest tightness	Turning blue	Shallow, rapid breathing	Difficulty talking from breathing
Wheezing	Rapid, labored breathing	Blueness of fingernails & lips	Decreased or loss of consciousness

Steps to Take During an Asthma Episode

1. Give emergency asthma medications as indicated below.

Quick Relief Medications	Dose/Frequency	When to Administer

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
  - Child is hunching over
  - Child is struggling to breathe

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Part 2: Medication Authorization

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's Signature _____ Date _____

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 _____