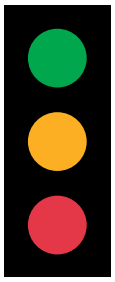
ASTHMA ACTION PLAN

Asthma and Allergy Foundation of America
aafa.org

Name:	Date:
Doctor:	Medical Record #:
Doctor's Phone #: Day	Night/Weekend
Emergency Contact:	
Doctor's Signature:	

The colors of a traffic light will help you use your asthma medicines.



GREEN means Go Zone!
Use preventive medicine.

YELLOW means Caution Zone!
Add quick-relief medicine.

RED means Danger Zone!
Get help from a doctor.

Personal Best Peak Flow: _____

GO

You have *all* of these:
- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work & play

Peak flow:
from _____
to _____

Use these daily preventive anti-inflammatory medicines:

MEDICINE	HOW MUCH	HOW OFTEN/WHEN
For asthma with exercise, take:		

CAUTION

You have *any* of these:
- First signs of a cold
- Exposure to known trigger
- Cough
- Mild wheeze
- Tight chest
- Coughing at night

Peak flow:
from _____
to _____

Continue with green zone medicine and add:

MEDICINE	HOW MUCH	HOW OFTEN/ WHEN

CALL YOUR PRIMARY CARE PROVIDER.

DANGER

Your asthma is getting worse fast:
- Medicine is not helping
- Breathing is hard & fast
- Nose opens wide
- Ribs show
- Can't talk well

Peak flow:
reading below _____

Take these medicines and call your doctor now.

MEDICINE	HOW MUCH	HOW OFTEN/WHEN

GET HELP FROM A DOCTOR NOW! Do not be afraid of causing a fuss. Your doctor will want to see you right away. It's important! If you cannot contact your doctor, go directly to the emergency room. DO NOT WAIT. Make an appointment with your primary care provider within two days of an ER visit or hospitalization.

Acalanes Union High School District
Medication Form/Parent Permission

To be filled out and submitted upon student's enrollment with the AUHSD or when there are changes to medication-related information.

You can complete this form on your own computer. To move from field to field, use the Tab key. You may then print the completed document and if desired, save the document template to your own computer.

Date: _____ **Student's Name:** _____ _____ _____
(Last) (First) (Middle)

School: _____ **Grade:** _____
(Full Name of School)

Acalanes H.S. 1200 Pleasant Hill Rd. Lafayette 94549 Fax 925-280-3971	Campolindo H.S 300 Moraga Rd. Moraga 94556 Fax 925-280-3951	Ctr. for Ind. Study 1963 Tice Valley Blvd. Walnut Creek 94595 Fax 925-280-3983	Las Lomas H.S. 1460 S. Main St. Walnut Creek 94596 Fax 925-280-3921	Miramonte H.S. 750 Moraga Way Orinda, CA 94563 Fax 925-280-3931

Medication to be given at school:

Medication	Dosage	Time given	Administration Route	Reason for medicine

To be completed by the Authorized Health Care Provider:

Student has permission to carry certain designated emergency medication at school (includes inhalers, insulin, allergic reaction kits) and self-administer such medication under the supervision of school personnel.

Permission: **Y** or **N** _____

Physician office stamp

Signature of Physician: _____

Name of Physician: _____ **Date:** _____

To be completed by the Parent/Guardian:

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. The parent/guardian is responsible for providing the medication, which should be sent in the original bottle and labeled with the student's name.

I request that medication be administered to my child in accordance with our authorized health care provider written instruction. I understand that designated non-medical 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-related information with the authorized health care provider. The school nurse may counsel appropriate school personnel regarding the medication and its possible side effects.

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

Name of Parent or Guardian: _____

Medications given at home:

Medication	Dosage	Time given