DEPARTMENT OF HEALTH
Edward G. Rendell, Governor
Calvin B. Johnson, M.D., M.P.H., Secretary of Health

Asthma Action Plan

(To be completed by Doctor/Nurse)

Return Color Copy To The School Nurse

PHILADELPHIA ALLIES AGAINST ASTHMA
Giving Children Freedom to Breathe

Name | Birth Date | Effective Date

School | Parent/Guardian | Parent's Phone

Doctor/Nurse's Name | Doctor/Nurse's Office Phone

Emergency Contact After Parent | Contact Phone

Asthma Severity: ☐ Mild Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Asthma Triggers: ☐ Colds ☐ Exercise ☐ Animals ☐ Dust ☐ Smoke ☐ Food ☐ Weather ☐ Other: _____

TAKE THESE MEDICINES EVERY DAY

Child feels good:
- Breathing is good
- No cough or wheeze
- Can work/play
- Sleeps all night

MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

Green

Peak flow in this area:
_____ to _____

20 MINUTES BEFORE EXEXCISE USE THIS MEDICINE:

IF NOT FEELING WELL

TAKE EVERYDAY MEDICINES AND (ADD) THESE RESCUE MEDICINES

Child has *any* of these:
- Cough
- Wheeze
- Tight Chest

MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

Yellow

Peak flow in this area:
_____ to _____

Call your doctor/nurse's office if the symptoms don't improve in 2 days OR if the flare lasts for longer than ___ days. After _____ days go back to GREEN ZONE and take everyday medications as instructed.

IF FEELING VERY SICK CALL THE DOCTOR OR NURSE NOW! TAKE THESE MEDICINES

Child has *any* of these:
- Medicine is not helping
- Breathing is hard and fast
- Lips and fingernails are blue
- Can't walk or talk well

MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

Red

Peak flow below:
_____

IF UNABLE TO CONTACT YOUR DOCTOR OR NURSE:
Call 911 or go to the nearest emergency room and bring this form with you!

I give permission to the doctor, nurse, health plan, and other health care providers to share information about my child's asthma to help improve the health of my child.

Parent/Guardian Signature | Date

Health Care Provider Signature

☐ **It is my professional opinion this child should carry his/her inhaled medication by him/herself.**

Adapted from the NYC Childhood Asthma Initiative

Adapted forms the NHLBI

Printed 10/2005

PERKIOMEN VALLEY SCHOOL DISTRICT
PROCEDURE FOR ADMINISTRATION OF MEDICATION

Dear Parent/Guardian:

According to the State Health Code, including the State Board of Nurse Examiners, the school nurse **may not administer** any medication **without a written order** from your child's physician indicating the name of the medication, the dosage, the reason it is being given, and the time to administer it in school. **This includes over-the-counter, non-prescription medication as well as prescription medication. Your signature is also required.** Permission slips must be completed each year.

In order for the school nurse to administer medications, the Perkiomen Valley School District requests that you ask your physician to complete the enclosed form. In the event your child needs medications, fill in the name of the medications on the enclosed form and ask your physician to sign it. Please have your child return the form to the school nurse. **Medication must be brought to school by the parent/guardian in its original container,** clearly labeled with child's name, name of medication, amount of dosage and time to be given.

After you and your physician complete the **Permit to Administer Medication** form, the school nurse will be glad to administer medication following the Pennsylvania State regulations. **Phone permission is not acceptable.** Thank you for your cooperation in this important matter.

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PERMIT TO ADMINISTER MEDICATIONS
(Signed permit good for current school year)

Student Name:_____ Room/Section:_____

Name of Medication:_____

Amount to be Given:_____ Dates to be Given:_____

Time to be Given:_____ Reason for Medication:_____

Side effects of medication:_____

Any necessary emergency response: _____

_____

_____ _____ _____
Signature of Physician Phone Number Date

_____ _____ _____
Signature of Parent/Guardian Phone Number Date

(Nov 7/08)