1004575248_25650 1_2

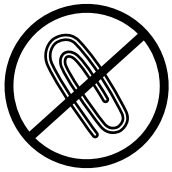
PLEASE DO NOT WRITE ABOVE THIS LINE - FOR MAGNUS HEALTH USE ONLY

Magnus Health

ASTHMA ACTION PLAN FORM

This coversheet is **ONLY** for the form and student listed above
and **MUST BE RECEIVED** for processing.

DO NOT use staples or paperclips!



Please print and complete this form then
submit all pages including this coversheet via:

FAX		MAIL
(877) 447-9530 Outside of the United States? Please fax to (978) 244-8894	-OR-	**Magnus Health Does Not Accept Mailed Forms**

Washington International School
3100 Macomb Street NW • Washington, DC 20008
MS/US Nurse 202.495.7301 • PS Nurse 202.243.1709

Asthma Action Plan

Name_____

Severity Classification	**Triggers**		**Exercise**
☐ Mild Intermittent	☐ Colds	☐ Smoke	Pre-medication (how much/when)
☐ Mild Persistent	☐ Exercise	☐ Dust	_____
☐ Moderate Persistent	☐ Animals	☐ Food	Exercise modifications
☐ Severe Persistent	☐ Pollen	☐ Weather	_____
	☐ Other _____		

GREEN ZONE: DOING WELL

Personal Best Peak Flow: _____ Peak flow in this area: _____ to _____

Symptoms
- Breathing is good
- No cough or wheeze
- Can work and play
- Sleeps all night

☐ **No control medication required**

☐ **Control medication required**

Provide name of medication, dosage, and administration schedule:

_____

YELLOW ZONE: CAUTION

Peak flow between 50-80% of personal best or between _____ and _____

Symptoms
- Some problems breathing
- Cough, wheezing or tight chest
- Problems working or playing

☐ **Rescue medication required**

Provide name of medication, dosage, and route of administration:

_____

_____

____Inhaler _____Inhaler with spacer _____Nebulizer

RED ZONE: EMERGENCY

Peak flow is less than 50% of personal best or less than _____ CALL "911"

Any of these symptoms
- Cannot talk, eat, or walk well
- Medicine not working
- Breathing hard and fast
- Blue lips and finger-nails
- Tired or lethargic
- Ribs showing

☐ **Rescue medication required**

Provide instructions for medication intervention while awaiting rescue squad

_____

_____

_____

SCHOOL MEDICATION CONSENT AND PROVIDER ORDER FOR CHILDREN/YOUTH AS REQUIRED BY DC LAW A17-107, STUDENT ACCESS TO TREATMENT ACT OF 2007

Healthcare Provider Initials:

_____ This student is capable and approved to self-administer the medicine(s) named above.

_____ This student is **not** approved to self-medicate**.**

Provider Signature_____ **Date**_____

As the Responsible Person:

_____ I hereby authorize a trained school employee to administer medication to the student.

_____ I hereby authorize the student to possess and self-administer medication.

_____ I understand that this student is **not** authorized to self-administer medication.

I agree that the school and its employees shall incur no liability and shall be held harmless against any claims that may arise relating to the administration, supervision, training, or self-administration of medication.

Parent Signature_____ **Date** _____

Adapted from the DC Department of Health and the American Lung Association