ALHAMBRA
UNIFIED SCHOOL DISTRICT
HEALTH AND NURSING SERVICES

ID photo

ASTHMA ACTION PLAN (includes Authorization for Asthma Medication as School)

Last Name: _____ First Name: _____ Birthdate: _____ Age: _____ School Year: _____
Phone: Home: _____ School: _____ Grade: _____ Room: _____
Parent(s)/Guardian(s) Name: _____ Work: _____ Cell: _____

The following is to be completed by the PHYSICIAN:

A. **QUICK –RELIEF:** (Rescue) Medications (e.g.: albuterol; Meds to give for Peak Flow < 80% or other symptoms)

Medication Name	Form (MDI, Neb)	Dosage or No. of puffs	Time
1. _____			
2. _____			

B. **ROUTINE:** (Controller) Medications (whether at school or at home):

Medication Name	Form (MDI, Neb)	Dosage or No. of puffs	Time
1. _____			
2. _____			

C. **Medications BEFORE P.E. Exertion:**

Medication Name	Form (MDI, Neb)	Dosage or No. of puffs	Time
1. _____			
2. _____			

D. **PEAK FLOW:** Write patient's "personal best" peak flow reading under the 100% box (below): Then multiply by .8 and .5 respectively to define the Green, Yellow and Red Zones

100%	Green Zone:	80%	Yellow Zone: Take Rescue Meds.	50%	Red Zone: Take Rescue Meds and begin Emergency Plan.

E. **DAILY ASTHMA MANAGEMENT:** Asthma Triggers

- ☐ Exercise
- ☐ Respiratory infections
- ☐ Change in temperature
- ☐ Animals
- ☐ Strong odors or fumes
- ☐ Chalk dust/dust
- ☐ Carpets in the room
- ☐ Pollens
- ☐ Molds
- ☐ Food _____
- ☐ Other _____

Comments: _____

F. **FOR MEDICATIONS AT SCHOOL:** For inhaled medications, choose one of two options:

It is the policy of the Alhambra School District to allow medication to be given to students at school only if attendance at school is dependent upon the medication. Education code 49423 allows this to be done if it carries out the recommendation of a physician. The district recognizes the desirability of following a physician's recommendation whenever possible. The fact that this is a service or accommodation, which the district is not legally required to perform, is recognized by all parties signing this form, and in so signing they agree to hold the school or its personnel free from any or all suits which might arise out of these arrangements.

Our school board policy requires all medication administered during the school day be stored in the health office and administered only when physician's and parent's forms are on file. If, in your opinion, this student's medical condition requires immediate use of prescribed medication and student's well being is in jeopardy unless the medication is carried on his/her person, the statement below needs to be signed by you.

☐ Assist student with medication in the office.

☐ Student may carry own medication.
His / her condition warrants immediate use of _____ (medication), and it is required that this medication be carried on his/her person. This student has demonstrated knowledge of correct dosage and usage.

G. **EMERGENCY PLAN AT SCHOOL:** School staff will give rescue medication, contact parent/guardian and /or seek emergency care (dial 911) if the student has any of the following:

- No improvement 15 minutes after initial treatment with rescue medication
- Peak flow is <50% of usual best.
- Trouble walking, talking or stops playing
- Breathing: chest/neck muscles retract, hunched, blue color

Physician's Name (print): _____ Signature: _____ Date: _____
Office Address: _____ Office Telephone #: _____

The following is to be completed by the PARENT OR GUARDIAN requesting medication in school:

- An adult must deliver the medication and this competed form to the school.
- Renew this form annually or earlier if doctor has put a time limit on the prescription.

I request that the school nurse or other designated person administer medications as directed by the physician (above). I authorize my child's doctor (named above) to communicate with school staff regarding my child's asthma to assist in implementing an asthma management plan. The authorization shall terminate at the end of the school year and can be revoked at any time by parent / legal guardian. I understand that I have the right to receive a copy of this authorization if I so request.

Parent's / Guardian's Signature _____ Date _____

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PHYSICIAN'S RECOMMENDATIONS FOR MEDICATION

This request must be filled and signed by a licensed physician, and then signed by parent or guardian and returned to the school nurse.

School: _____ Student ID #_____ Date: _____

_____ Birthdate: _____

Pupil's Last Name First Middle

It is the policy of the Alhambra School District to allow medication to be given to students at school only if attendance at school is dependent upon the medication. Education code 49423 allows this to be done if it carries out the recommendations of a qualified California licensed Health Care Professional. The district recognizes the desirability of following a physician's recommendations whenever possible.

If it is necessary for the above named student to receive medication at school, please fill in the following information:

Name of Medication	Form (pill, capsule, etc.)	Dosage	Time to be given
1._____	_____	_____	_____
2._____	_____	_____	_____

Diagnosis _____

Precautions/side effects, if any _____

IMPORTANT: THIS ORDER IS VALID TO END OF THIS SCHOOL YEAR. A new order is required each school year.

X _____ Date
Physician Signature License No.

_____ Telephone#
Print Physician's Name Address

I/we the parent(s) of _____ desire _____ to comply with the
Student's name School

orders of the above physician and request that the school assist our son/daughter with medication administration. I/we authorize communication between school health services and the physician regarding all questions and concerns related to the student's medication and condition for medication. I/we agree to obtain new doctor's orders whenever the medication is changed in dose, frequency, etc.

X _____ _____
Parent or Guardian's Signature Date

HS 35 (7/05)

ALHAMBRA
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HEALTH AND NURSING SERVICES

SELF ADMINISTRATION OF PRESCRIBED MEDICATION

Name: _____ Birthdate: _____
Last Name First Middle

School: _____ Student ID#: _____ Date: _____

Dear Doctor:

The parents of the above named student have advised us of your request to have their son/daughter carry _____ on his/her person to use for the treatment of _____.
Medication Health Problem

Our school board policy requires all medication administered during the school day be stored in the health office and administered only when physician's and parent's forms are on file. If, in your opinion, this student's medical condition requires immediate use of prescribed medication and student's well being is in jeopardy unless the medication is carried on his/her person, the statement below needs to be signed by you.

_____ is under my care. His/her condition warrants immediate use
Pupil's Last Name, First Middle
of _____, and it is required that this medication be carried on his/her person. In my
Medication
opinion, this student is competent to safely administer the medications according to the following order:

_____ _____ _____ _____
Dosage Time/frequency Start/Stop dates Diagnosis

Precautions/side effects, if any _____

IMPORTANT: THIS ORDER IS VALID TO END OF THIS SCHOOL YEAR. A new order is required each school year.

X _____
Physician Signature License No. Date

_____
Print Physician's Name Address Telephone#

I/we the parent(s) of _____ desire _____ to comply with the
Student's name School
orders of the above physician and request that the school assist our son/daughter with medication administration. I/we authorize communication between school health services and the physician regarding all questions and concerns related to the student's medication and condition for medication. I/we agree to obtain new doctor's orders whenever the medication is changed in dose, frequency, etc.

X _____ _____
Parent or Guardian's Signature Date

HS127 (7/05)