

My Asthma Plan

ENGLISH

Patient Name: _____

Medical Record #: _____

Provider's Name: _____

DOB: _____

Provider's Phone #: _____

Completed by: _____ Date: _____

Controller Medicines	How Much to Take	How Often	Other Instructions
		_____ times per day EVERY DAY!	<input type="checkbox"/> Gargle or rinse mouth after use
		_____ times per day EVERY DAY!	
		_____ times per day EVERY DAY!	
		_____ times per day EVERY DAY!	
Quick-Relief Medicines	How Much to Take	How Often	Other Instructions
<input type="checkbox"/> Albuterol (ProAir, Ventolin, Proventil) <input type="checkbox"/> Levalbuterol (Xopenex)	<input type="checkbox"/> 2 puffs <input type="checkbox"/> 4 puffs <input type="checkbox"/> 1 nebulizer treatment	Take ONLY as needed (see below — starting in Yellow Zone or before exercise)	NOTE: If you need this medicine more than two days a week, call physician to consider increasing controller medications and discuss your treatment plan.

Special instructions when I am  *doing well*,  *getting worse*,  *having a medical alert*.

Doing well.

- No cough, wheeze, chest tightness, or shortness of breath during the day or night.
- Can do usual activities.



Peak Flow (for ages 5 and up):
is _____ or more. (80% or more of personal best)

Personal Best Peak Flow (for ages 5 and up): _____

PREVENT asthma symptoms every day:

- Take my controller medicines (above) every day.
- Before exercise, take _____ puff(s) of _____
- Avoid things that make my asthma worse. (See back of form.)

GREEN ZONE

Getting worse.

- Cough, wheeze, chest tightness, shortness of breath, or
- Waking at night due to asthma symptoms, or
- Can do some, but not all, usual activities.



Peak Flow (for ages 5 and up):
_____ to _____ (50 to 79% of personal best)

CAUTION. Continue taking every day controller medicines, AND:

- Take _____ puffs or _____ one nebulizer treatment of quick relief medicine. If I am not back in the **Green Zone** within 20-30 minutes take _____ more puffs or nebulizer treatments. If I am not back in the **Green Zone** within one hour, then I should:
- Increase _____
- Add _____
- Call _____
- Continue using quick relief medicine every 4 hours as needed. Call provider if not improving in _____ days.

YELLOW ZONE

Medical Alert

- Very short of breath, or
- Quick-relief medicines have not helped, or
- Cannot do usual activities, or
- Symptoms are same or get worse after 24 hours in Yellow Zone.



Peak Flow (for ages 5 and up):
less than _____ (50% of personal best)

MEDICAL ALERT! Get help!

- Take quick relief medicine: _____ puffs every _____ minutes and get help immediately.
- Take _____
- Call _____

RED ZONE

Danger! Get help immediately! Call 911 if trouble walking or talking due to shortness of breath or if lips or fingernails are gray or blue. For child, call 911 if skin is sucked in around neck and ribs during breaths or child doesn't respond normally.

Health Care Provider: My signature provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. Student may self carry asthma medications: Yes No self administer asthma medications: Yes No (This authorization is for a maximum of one year from signature date.)

Healthcare Provider Signature _____

Date _____

ORIGINAL (Patient) / CANARY (School/Child Care/Work/Other Support Systems) / PINK (Chart)

SCHOOL AUTHORIZATION FORM

ENGLISH

To be completed by Parent/Guardian and turned in to the school

AUTHORIZATION AND DISCLAIMER FROM PARENT/GUARDIAN: I request that the school assist my child with the asthma medications listed on this form, and the Asthma Action Plan, in accordance with state laws and regulations.

Yes No.

My child may carry and self-administer asthma medications and I agree to release the school district and school personnel from all claims of liability if my child suffers any adverse reactions from self-administration of asthma medications:

Yes No.

Parent/Guardian Signature

Date

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION TO SCHOOL DISTRICTS

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Federal laws (including HIPAA) concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

USE AND DISCLOSURE INFORMATION:

Patient/Student Name: _____ / _____
Last First MI Date of Birth

I, the undersigned, do hereby authorize (name of agency and/or health care providers):

(1) _____ (2) _____ to provide health information from the above-named child's medical record to and from:

School or school district to which disclosure is made

Address / City and State / Zip Code

Contact person at school or school district

Area Code and Telephone Number

The disclosure of health information is required for the following purpose:

Requested information shall be limited to the following: All health information; or Disease-specific information as described:

DURATION:

This authorization shall become effective immediately and shall remain in effect until _____ (enter date) or for one year from the date of signature, if no date entered.

RESTRICTIONS:

Law prohibits the Requestor from making further disclosure of my health information unless the Requestor obtains another authorization form from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS:

I understand that I have the following rights with respect to this Authorization: I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the health care agencies/persons listed above. My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance to this Authorization.

RE-DISCLOSURE:

I understand that the Requestor (School District) will protect this information as prescribed by the Family Equal Rights Protection Act (FERPA) and that the information becomes part of the student's educational record. The information will be shared with individuals working at or with the School District for the purpose of providing safe, appropriate, and least restrictive educational settings and school health services and programs.

I have a right to receive a copy of this Authorization. Signing this Authorization may be required in order for this student to obtain appropriate services in the educational setting.

APPROVAL:

Printed Name

Signature

Date

Relationship to Patient/Student

Area Code and Telephone Number