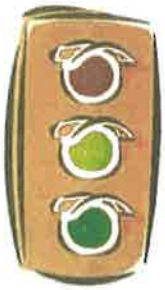
MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™
Maryland Chapter

ASTHMA ACTION PLAN

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

Patient's Name	DOB	Effective Date ___/___/___ to ___/___/___
Doctor's Name Signature	Parent/ Guardian's Name	
Doctor's Office Phone Number	Parent/ Guardian's Phone Number	
Emergency Contact after Parent	Contact Phone	



Personal Best Peak Flow: _____
Personal Peak Flow Ranges

RED means Danger Zone! Get help from a doctor. – _____

YELLOW means Caution Zone! Add prescribed yellow medicine. – _____

GREEN means Go Zone! Use preventive medicine. – _____

GO (Green) → Use these medications every day.

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

And/ or personal peak flow above 80% _____

Medicine/ Dosage	How much to take	When to take it
Comments		

For exercise, take:

CAUTION (Yellow) → Continue with green zone medicine and ADD:

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

And/ or personal peak flow from 80% _____ To 50% _____

Medicine/ Dosage	How much to take	When to take it
Comments		

If Quick Reliever/ Yellow Zone medicines are used more than 2 to 3 times per week, CALL your Doctor.

DANGER (Red) → Take these medicines and call your doctor.

Your asthma is getting worse fast:
- Medicine is not helping within 15-20 minutes.
- Breathing is hard and fast.
- Nose opens wide.
- Ribs show.
- Lips blue.
- Fingernails blue.
- Trouble walking or talking.

And/ or personal peak flow below 50% _____

Medicine/ Dosage	How much to take	When to take it
Comments		

GET HELP FROM A DOCTOR NOW!

If you cannot contact your doctor, go directly to the emergency room. DO NOT WAIT.

Trigger List:
- ☐ Chalk dust
- ☐ Cigarette smoke
- ☐ Colds/Flu
- ☐ Dust or dust mites
- ☐ Stuffed animals
- ☐ Carpet
- ☐ Exercise
- ☐ Mold
- ☐ Ozone alert days
- ☐ Pests
- ☐ Pets
- ☐ Plants, flowers, cut grass, pollen
- ☐ Strong odors, perfume, cleaning products
- ☐ Sudden temperature change
- ☐ Wood smoke
- ☐ Foods: _____ _____
- ☐ Other: _____

Adapted from: NYC DOHMH and Pediatric/ Adult Asthma Coalition of New Jersey.
For additional forms please call: 410-799-1940

www.fha.state.md.us/mch www.MarylandAsthmaControl.org www.mdaap.org

DHMH Form Number: 4643

Asthma Action Plan (continued)

Student's Name: _____ Date of Birth: _____

Teacher's Name: _____ Room #: _____

School will:

- ☐ A Certified Medication Technician on site with on-call Delegating RN
- ☐ Have staff trained in CPR & First Aid
- ☐ Have staff trained in Allergy & Anaphylaxis, Asthma Signs & Symptoms, and Administration of Inhaler or Nebulizer
  → administering EpiPen® including demonstration & practice
- ☐ Emergency List distributed to school staff
- ☐ Have staff trained on individual emergency plans
- ☐ School staff will make every reasonable effort to prevent the student's exposure to known allergens and Asthma triggers
- ☐ Other_____

Parents will:

- ☐ Provide pertinent health information to the school
- ☐ Provide Physician Authorization Forms and Action Plans
  → for student medication and specific action plans for emergency care
- ☐ Provide current, non-expired medications
- ☐ Provide spacer if indicated, as needed by physician
- ☐ Other:_____
- ☐ Other:_____

Student will:

- ☐ Come to office to use inhaler prior to exercise
- ☐ Alert nearest adult if they experience any symptoms of Asthma (cough, wheezing, shortness of breath
- ☐ If self-carrying and self-administering, student will demonstrate responsibility by carrying their inhaler and notifying adult when they have used it, and committing to not sharing medication with any other person.

Notes:

Mother of God School

Medication Form – Physician's Order

To be completed by the Physician/Authorized Health Care Providor

School: _____ Grade: _____ Date of Order: _____

Order Expires at End of School Year (Y/N) or Date: _____ Order Valid for Current Year/Summer (Check if Yes) ☐

Student Name: _____ DOB: _____ Sex: male / female

Name of Medication: _____ Dose: _____ Route: _____ Time to Administer: _____

Reason for Medication: _____ Frequency of Medication (if PRN): _____

Possible Side Effects: _____

Student may carry and self-administer emergency medication: ☐ Yes ☐ No

Parent/Guardian Name: _____ **Physician Name:** _____ **Phone:** _____

Parent/Guardian Phone: _____ **Physician Address:** _____

Parent/Guardian Signature: _____ **Prescriber Signature:** _____

Medication Administration Record (For School Use Only)

Nurse Reviewed: **Dates Reviewed:**

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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May																															
Jun																															
Jul																															

Name/Postion: _____ Initials: _____

_____ _____

_____ _____

_____ _____

_____ _____

RN Signature: _____

Name/Position: _____ Initials: _____

_____ _____

_____ _____

_____ _____

_____ _____

Date: _____

CODES: Chart Reasong (See H.S. Manual)

X: School Closed
A: Absent
N: None Available
NS: No Show to HR
D/C: Med Discont.
L/E: Late Arr./Early Dis.
FT: Field Trip
R: Refused
O: Omitted
H: Dose Held

20501 Goshen Road, Gaithersburg, MD 20879 Phone: (301) 990-2088 Fax: (301) 947-0574 www.mogschool.com

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Medication Form – Physician's Order

Student Name: _____

Date	Time	Student Complaint	RN Consulted √	Medication Administered as Ordered √	Student Outcome	Staff Initials	Parent Notified √

Comments:

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