FAMILY TO RETAIN A COPY

Controlling Things That Make Asthma Worse

❑ SMOKE

- Do not smoke. Attend classes to help stop smoking.
- Do not allow smoking in the home or car. Remaining smoke smell can trigger asthma.
- Stay away from people who are smoking.
- If you smoke, smoke outside.

❑ DUST

- Vacuum weekly with a vacuum with a high efficiency filter or a central vacuum. Try to make sure people with asthma are not home during vacuuming.
- Remove carpet if possible. Wet carpet before removing and then dry floor completely.
- Damp mop floors weekly.
- Wash bedding and stuffed toys in hot water every 1-2 weeks. Freeze stuffed toys that aren't washable for 24 hours.
- Cover mattresses and pillows in dust-mite proof zippered covers.
- Reduce clutter and remove stuffed animals, especially around the bed.
- Replace heating system filters regularly.

❑ PESTS

- Do not leave food or garbage out. Store food in airtight containers.
- Try using traps and poison baits, such as boric acid for cockroaches. Instead of sprays/bombs, use baits placed away from children, such as behind refrigerator.
- Vacuum up cockroach bodies and fill holes in with caulking or copper wool.
- Fix leaky plumbing, roof, and other sources of water.

❑ MOLD

- Use exhaust fans or open windows for cross ventilation when showering or cooking.
- Clean mold off hard surfaces with detergent in hot water and scrub with stiff brush or cleaning pad, then rinse clean with water. Absorbent materials with mold may need to be replaced.
- Make sure people with asthma are not in the room when cleaning.
- Fix leaky plumbing or other sources of water or moisture.

❑ ANIMALS

- Consider not having pets. Avoid pets with fur or feathers.
- Keep pets out of the bedroom of the person with asthma.
- Wash your hands and the hands of the person with asthma after petting animals.

❑ ODORS/SPRAYS

- Avoid using strongly scented products, such as home deodorizers and incense, and perfumed laundry products and personal care products.
- Do not use oven/stove for heating.
- When cleaning, keep person with asthma away and don't use strong smelling cleaning products.
- Avoid aerosol products.
- Avoid strong or extra strength cleaning products.
- Avoid ammonia, bleach, and disinfectants.

❑ POLLEN AND OUTDOOR MOLDS

- Try to stay indoors when pollen and mold counts are high.
- Keep windows closed during pollen season.
- Avoid using fans; use air conditioners.

❑ COLDS/FLU

- Keep your body healthy with enough exercise and sleep.
- Avoid close contact with people who have colds.
- Wash your hands frequently and avoid touching your hands to your face.
- Get an annual flu shot.

❑ WEATHER AND AIR POLLUTION

- If cold air is a problem, try breathing through your nose rather than your mouth and covering up with a scarf.
- Check for Spare the Air days and nights and avoid strenuous exercise at those times.
- On very bad pollution days, stay indoors with windows closed.

❑ EXERCISE

- Warm up before exercising.
- Plan alternate indoor activities on high pollen or pollution days.
- If directed by physician, take medication before exercise. (See Green Zone of Asthma Action Plan.)

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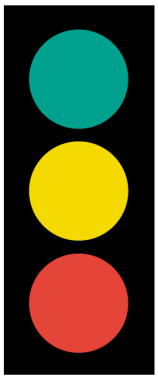
Asthma Action Plan

Asthma and Allergy Foundation of America www.aafa.org

Name	Date
Doctor	Medical Record #
Doctor's Office Phone #: Day	Night/Weekend
Emergency Contact	
Doctor's Signature	



The Colors of a traffic light will help you use your asthma medicines.

Green means **Go Zone!**
Use preventive medicine.

Yellow Means **Caution Zone!**
Add quick-relief medicine.

Red means **Danger Zone!**
Get help from a doctor.

Personal Best Peak Flow _____

GO GREEN

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

Peak flow from _____ to _____

Use these daily preventive anti-inflammatory medicines:

MEDICINE	HOW MUCH	HOW OFTEN/WHEN

For asthma with exercise, take:

CAUTION YELLOW

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

Peak flow from _____ to _____

Continue with green zone medicine and add:

MEDICINE	HOW MUCH	HOW OFTEN/WHEN

CALL YOUR PRIMARY CARE PROVIDER.

DANGER RED

Your asthma is getting worse fast:
- Medicine is not helping
- Breathing is hard and fast
- Nose opens wide
- Ribs show
- Can't talk well

Peak flow reading below _____

Take these medicines and call your doctor now.

MEDICINE	HOW MUCH	HOW OFTEN/WHEN

GET HELP FROM A DOCTOR NOW! Do not be afraid of causing a fuss. Your doctor will want to see you right away. It's important! If you cannot contact your doctor, go directly to the emergency room. DO NOT WAIT.

Make an appointment with your primary care provider within two days of an ER visit or hospitalization.

MEDICATION ASSISTANCE AUTHORIZATION

Student Name:_____SIS#:_____D.O.B._____

Address: _____

School:_____Grade:____ Teacher:_____

Parent/Guardian Phone: Home:_____ Work:_____Cell:_____Emergency:_____

IMPORTANT INFORMATION

In accordance with California Education Code Section 49423, Section 504 of the Rehabilitation Act of 1973, and Title II of the Americans with Disabilities Act of 1990, students who have a Medical Disability for which a physician has prescribed Medication to be taken during the school day, whether of limited or permanent duration, are entitled to seek assistance from the District in meeting their Medication needs when the student is under the District's care, custody, or control, including while the student is on field trips, sporting events, and other off-campus District-sponsored activities. **Except for personal asthma inhalers, personal epi-pens, and glucagon kits, a student may not independently possess Medication during the school day or while on District property**. Due to health and safety concerns, including the potential theft of the Medication or the potential for improper sharing/use of the Medication by other students who may then suffer unexpected allergic or other negative reactions, **there are no exceptions to this requirement**. A student personally possessing Medication, misusing Medication, or providing Medication to another student, may face discipline.

> ***Medication****, means currently (unexpired) prescribed Medications, as well as over-the-counter remedies (such as aspirin, decongestant, eye drops) and nutritional/herbal supplements. Because several over-the-counter medications can present safety or health hazards to others, all Medications are subject to the following rules and regulations.*
>
> ***Medical Disability****, means any mental or physical condition limiting a student's ability to engage in major life activities (such as eating, breathing, hearing, speaking, learning, or performing self-care) or which otherwise is subject to a medical disability or condition for which Medication has been prescribed or recommended by a physician.*
>
> ***Medication Assistance****, means the storage of Medication, or the providing of Medication to a student in accordance with a physician's written instructions or directives, when the child presents himself/herself at the agreed time, or in response to urgent or emergency circumstances. As permitted by law, assistance may be provided by a District employee other than a nurse or licensed or trained medical care provider. Any emergency assistance provided to a student will be promptly brought to the attention of the parent/guardian. All additional reports/reporting of emergency Assistance will be undertaken in keeping with governing laws and District policies and procedures.*

Before Medication Assistance can be provided, even if the student has an Individualized Education Plan ("IEP") or a "504 Plan," this Medication Assistance Authorization form ("Authorization") must be executed by at least one parent/legal guardian **and** the student's duly authorized health care provider. A new Authorization is required at the beginning of each school year **and** any time there is a change in Medication directives (such as change in Medication, dosage, timing, or frequency). The parent/legal guardian must immediately notify the District of any change in Medication directives.

All Medication must be provided to the District by a parent/legal guardian, with the District storing the Medication and dispensing it in compliance with the Medication directive. All medication supplied to the District must be in its original labeled form (i.e., in the original prescription bottle, sealed package, etc.) as received from the physician, pharmacist, or store. Until the District receives an updated Authorization, signed by the parent/legal guardian and health care provider, the District will continue to provide the provided Medication, and provide Medication Assistance according to an existing Authorization, unless (a) there is evidence the student's health may be endangered by the continued use of the former Medication directive, or (b) the parent/legal guardian provides a written statement that Medication Assistance is to cease or be suspended until the new Authorization can be provided. In such situations, the parent/legal guardian will need to provide the Medication Assistance to the student at agreed times during the school day in a safe and appropriate manner that does not unduly disrupt the educational environment.

PARENT/GUARDIAN AUTHORIZATION

I have read, understand, and agree to be bound by the rights and obligations contained in the Important Information section of this Authorization. I request that Medication Assistance be provided to my Student.

The Student understands his/her obligations described in the Important Information section above, including the need to ensure he/she complies with the directions for receiving Medication Assistance (i.e., coming to the school or nurse's office each day, at the same time, without need for a District employee to attempt to locate them) and the policy against his/her personal possession or sharing of Medication (except for asthma inhalers and epi-pens). I understand that if the Student fails to meet these obligations that he/she may face discipline and/or this Authorization may be revoked.

Unless required by law, I understand there is no guarantee that Medication Assistance will be performed by a nurse or licensed health care provider, although the District will take reasonable steps to ensure that the District employee providing Assistance has received training that complies with all legal requirements. As a partner with the District in protecting the Student's health and safety, I will work with school staff regarding Medication Assistance issues, including Medication Assistance issues when the Student is expected to be involved in off-campus District-sponsored activities. I will also timely advise the District of any change in Medication directives. It is my responsibility to obtain a new Authorization form, signed by a licensed health care provider, when there is a change in Medication directives. I will comply with my responsibilities described above should those Medication directives change.

With respect to the Medication Assistance issues covered by this Authorization, I authorize the District and the health care provider below to discuss the student's medical and/or Medication information, I authorize the health care provider to provide any additional information to the District as may be necessary to carry out this Authorization, and I authorize the disclosure of this information to all District employees and trained volunteers who may supervise, or regularly interact with, the Student.

_____	_____	_____
Date	Signature Parent/Guardian	Printed Name Parent/Guardian

PHYSICIAN AUTHORIZATION

_____ (student name) is under my care and I have personally direct the following: **(If more than two medications are prescribed, or more explanation is needed, physically attach to this Authorization a separate signed sheet noting the additional information**)

1st Med. Name	Dosage	Method of Admin.	Duration (date/week/month/until discontinued)
	☐ Regular (if yes, add Interval/Time of Day)	☐ Emergency basis (Must Describe Symptoms/Triggers)	☐ As Needed (Must Describe Symptoms/Triggers)
Student capable of self-administering? ☐Yes ☐No		Student may/should carry medication? ☐Yes ☐No (applies only to inhalers/epi-pens)	
Must a District employee have special training/experience before providing assistance? ☐Yes ☐No (If yes, describe the training/experience).			
Post Assistance Care/Potential Adverse Reactions/Follow-up/Emergency Care:			
2st Med. Name	Dosage	Method of Admin.	Duration (date/week/month/until discontinued)
	☐ Regular (if yes, add Interval/Time of Day)	☐ Emergency basis (Must Describe Symptoms/Triggers)	☐ As Needed (Must Describe Symptoms/Triggers)
Student capable of self-administering? ☐Yes ☐No		Student may/should carry medication? ☐Yes ☐No (applies only to inhalers/epi-pens)	
Must a District employee have special training/experience before providing assistance? ☐Yes ☐No (If yes, describe the training/experience).			
Post Assistance Care/Potential Adverse Reactions Requiring Follow-up/Emergency Care:			

Additional Remarks/Directions_____

Physician's Name _____ Medical License No. _____
Address _____ Telephone Number _____
Physician s Signature_____ Date _____