

AUTHORIZATION FOR PEAK FLOW MONITORING AND ACTION PLAN

THIS FORM IS VOID IF ALTERED IN ANY WAY

INSTRUCTIONS: Each of the three sections must be completed by the appropriate person as follows: Parts I and II by Parent/Guardian, Part III by Physician. Please return the completed form to the school health room/office.

I. STUDENT INFORMATION (To Be Completed By Parent/Guardian).

Student's Name (Last, First, Middle)		Birth Date	Medicaid #	Grade/Homeroom Teacher
Parent/Guardian		Address		
Home Phone	Work Phone	Other Phone (Cellular, Beeper, etc.)		
Number of Hospitalizations for Asthma		Date of Last Hospitalization for Asthma		

II. ACTION PLAN (To be Completed By Physician). Please complete all spaces.

Diagnosis: ASTHMA (Refer to NIH Guidelines for classification on the reverse side).
 _____ Mild Intermittent _____ Mild Persistent _____ Moderate Persistent _____ Severe Persistent

Peak Flow Monitoring Schedule (Select appropriate schedule for student):
 _____ As needed with symptoms _____ Daily, before P.E.
 _____ Daily, at beginning of school day _____ Other _____

Action Plan for Peak Flow Readings (Physician to insert appropriate numerical reading for each category and medication as applicable).
 Peak Flow Best: _____ Usual Peak Flow: _____ (Range)

NORMAL Green Zone	CAUTION Yellow Zone	EMERGENCY Red Zone
Greater than _____	Less than _____	Less than _____
1. Document reading on Student Medication Record. 2. Return to class.	1. Document reading on Student Medication Record 2. Administer 1 dose of authorized medication _____ 3. Repeat peak flow reading in 20 mins. - If Green Zone: Return to Class. No exercise today. Notify parent - If Yellow Zone: Call parent to take student home. - If Red Zone: Call 911; Contact parent and notify physician immediately.	1. Document reading on Student Medication Record. 2. Administer 1 dose of authorized medication: _____ 3. Call 911; Contact parent and notify physician immediately. 4. Continue to monitor peak flow readings every 5 minutes.

Print Physician's Name	Physician's Address	Phone
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Physician's Signature: _____ Date: _____

III. PARENTAL PERMISSION (To Be Completed By Parent/Guardian). Form is void if this section is incomplete.

I hereby request the school's personnel, or its agents, to assist in the asthma management procedure for my child as prescribed by the doctor. I understand that there is no liability on the part of the school district, its personnel, or agents, including Escambia County Health Department personnel, for civil damages as a result of assisting with this procedure when the person acts as an ordinarily reasonably prudent person would have acted under the same or similar circumstances. I hereby authorize the exchange of medical information regarding my child's plan for asthma management between the physician and school health personnel of the Escambia County Health Department and the School District of Escambia County. Furthermore, if my child is covered by Medicaid and receives health services under an IEP, I consent for the school district to bill Medicaid for those services.

Parent/Guardian Signature: _____ Date: _____

Classification of Severity: Clinical Features Before Treatment*

	Symptoms**	Nighttime Symptoms	Lung Function
STEP 4 Severe Persistent	<ul style="list-style-type: none"> • Continual symptoms • Limited physical activity • Frequent exacerbations 	Frequent	<ul style="list-style-type: none"> • FEV₁ or PEF \leq 60% predicted • PEF variability > 30%
STEP 3 Moderate Persistent	<ul style="list-style-type: none"> • Daily symptoms • Daily use of inhaled short-acting beta₂-agonist • Exacerbations affect activity • Exacerbations \geq 2 times a week; may last days 	> 1 time a week	<ul style="list-style-type: none"> • FEV₁ or PEF > 60% \leq 80% predicted • PEF variability > 30%
STEP 2 Mild Persistent	<ul style="list-style-type: none"> • Symptoms > 2 times a week but < 1 time a day • Exacerbations may affect activity 	>2 times a month	<ul style="list-style-type: none"> • FEV₁ or PEF \geq 80% predicted • PEF variability 20-30%
STEP 1 Mild Intermittent	<ul style="list-style-type: none"> • Symptoms \leq 2 times a week • Asymptomatic and normal PEF between exacerbations • Exacerbations brief (from a few hours to a few days); intensity may vary 	\leq 2 times a month	<ul style="list-style-type: none"> • FEV₁ or PEF \geq 80% predicted • PEF variability < 20%

* The presence of one of the features of severity is sufficient to place a patient in that category. An individual should be assigned to the most severe grade in which any feature occurs. The characteristics noted in this figure are general and may overlap because asthma is highly variable. Furthermore, an individual's classification may change overtime.

** Patients at any level of severity can have mild, moderate, or severe exacerbations. Some patients with intermittent asthma experience severe and life-threatening exacerbations separated by long periods of normal lung function and no symptoms.

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PERSONNEL TRAINED IN INDIVIDUAL STUDENT'S CARE
(To Be Completed By School Nurse)

Trained Provider's Name	Performs Peak Flow Procedure	Interprets Peak Flow Reading	Identifies Appropriate Action Step	School Nurse's Signature/Date