Asthma Action Plan

Student's Name_____ Grade_____ Date of Birth:_____ School_____

Inhaler kept in_____ ❑ School clinic ❑ Self-carry

ACTION CONTROL PLAN

Level of Severity ❑ Intermittent ❑ Mild Intermittent ❑ Moderate ❑ Persistent ❑ Severe Persistent ❑ High Risk

Control ❑ Well controlled ❑ Not well controlled ❑ Very poorly Controlled

Triggers ❑ Animals ❑ Pollen ❑ Dust Mites ❑ Viral Respiratory Infections ❑ Mold ❑ Exercise ❑ Weather ❑ Smoke ❑ Other

Allergies _____

Pulse Ox
❑ ≥ 95% normal
❑ Other_____

If student has any of the following symptoms – chest tightness, difficulty breathing, wheezing, excessive coughing, shortness of breath you will do this: Stop activity and help student to a sitting position, stay calm, reassure student, assist student with use of inhaler if they self-carry, escort student to school clinic or call for nurse for immediate assistance. Never send student to clinic alone!!!

GREEN ZONE – DOING WELL

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

And, if a peak flow meter is used,

Peak flow: more than_____
(80 percent or more of best peak flow)

Take these long-term control medicines each day.

Controller Medications	How much to take	When to take it	At School
_____	_____	_____	❑ Yes ❑ No
_____	_____	_____	❑ Yes ❑ No
❑ **Rescue** Medications	❑ 2 or ❑ 4 puffs ❑ 6 puffs	❑ 10 – 20 minutes before exercise	❑ Yes ❑ No
_____	❑ PRN_____hrs	_____	

YELLOW ZONE – ASTHMA IS GETTING WORSE

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

-Or-

If pulse Oximeter is used O2 Sat
_____% to_____%

First **Add: rescue medicine**

_____ ❑ 2 or ❑ 4 ❑ 6 puffs, every _____ Minutes Repeat every _____Minutes for up to 1 hour
(short-acting beta2-agonist) ❑ Nebulizer solution_____Repeat every_____Minutes

Second **If symptoms (and peak flow, if used) return to GREEN ZONE after 1 hour of above treatment:**

❑ Continue monitoring to be sure student stays in the GREEN ZONE.

-Or-

If symptoms (and or pulse Ox, if used) do not return to GREEN ZONE after 1 hour of above treatment move to RED ZONE.

RED ZONE – MEDICAL ALERT! DANGER

- Very short of breath, or
- Rescue medicines have not helped,
- Cannot do usual activities, or
- Symptoms are same or get worse after treatment in Yellow Zone Pulse Oximeter < 93%

First **Rescue medicine**

❑_____ ❑ 4 or ❑ 6 puffs every _____Minutes or Nebulizer Solution every_____Minutes
(short-acting beta2-agonist)

Second **Call 911 if unable to return action to yellow zone after 15 minutes or less, call 911, and parent/guardian.**

EMERGENCY! ■Trouble walking and talking due to shortness of breath ■Lips or fingernails are blue ■Chest or neck is pulling in while breathing ■Student must bend forward to breathe

Self Administration ❑ By checking this box and signing below, health care provider and parent, give written authorization of permission for this student to self carry and self administer prescription asthma medication during school or at school related events. This includes authorization to coach and discuss this condition and elements of care with health care provider indicated on this form

Date_____ Provider Signature_____ Provider Printed Name_____ Provider Phone_____ Fax _____

Parent/Guardian: I give written authorization for the medications listed in the action plan to be administered in school by the nurse or other school members as appropriate.
I consent to communication between the prescribing health care provider/clinic, the school nurse, the school medical advisor, and for asthma management and administration of this medication.

Date _____ Parent/guardian signature _____ Home phone/cell _____ Work_____ Alternate contact number _____

Nurse Signature:_____ Nurse Name:_____ Office Phone:_____ Fax:_____