

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

Rescue Medications

How much to take

2 or 4 puffs 6 puffs

PRN _____ hrs

When to take it

10 - 20 minutes before exercise

At School

Yes No

Yes No

Yes No

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: _____