

School Name: \_\_\_\_\_ **ASTHMA ACTION PLAN** Fax Number: \_\_\_\_\_

Student Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ School \_\_\_\_\_

Student ID Number \_\_\_\_\_ Grade \_\_\_\_\_ Medication Allergies \_\_\_\_\_

Activities student participates in at school: \_\_\_\_\_

Asthma symptoms are triggered by:

Exercise  Illness  Pollen  Smoke  Dust  Air Pollution  Animals  Cold Air  Molds  Foods (list)

Please list any other triggers: \_\_\_\_\_

Usual Asthma Symptoms:  Cough  Shortness of Breath  Chest Tightness  Wheeze  Other \_\_\_\_\_

If a student has any of the following symptoms: **chest tightness, difficulty breathing, wheezing, excessive coughing, shortness of breath**

1. Stop activity & help student to a sitting position
2. Stay calm, reassure student
3. Assist student with the use of their inhaler
4. Escort student to the health room or call for health room staff for immediate assistance. Never send the student to the health room alone!

**INHALER IS KEPT:** \_\_\_\_\_

**Call 911 for any of these!**

- If breathing does not improve after medication is given
- Student is having trouble walking or talking
- Student is struggling to breathe
- Student's chest and/or neck is pulling in while breathing
- Student's lips are blue, and/or
- Student must hunch over to breathe

**HEALTH CARE PROVIDER, Please complete all items in box:** ICD 9 Code:  493.9 or \_\_\_\_\_

Asthma Severity:  Intermittent  Mild persistent  Moderate persistent  Severe persistent

**Controller Medication given at home:**

Name of Medication \_\_\_\_\_ how much/mgs \_\_\_\_\_ how often \_\_\_\_\_

Name of Medication \_\_\_\_\_ how much/mgs \_\_\_\_\_ how often \_\_\_\_\_

**Quick Relief Medication:**

Albuterol \_\_\_\_\_ puffs every \_\_\_\_\_ min. and as needed up to \_\_\_\_\_ puffs per hour. May repeat every \_\_\_\_\_ hrs

Albuterol 10-15 min before exercise  Routinely  As Needed. Activity limitations: \_\_\_\_\_

OR, Albuterol or ( \_\_\_\_\_ ) solution as needed, \_\_\_\_\_ mg by nebulizer every \_\_\_\_\_ to \_\_\_\_\_ hours

**GREEN ZONE**

\*Peak Flow \_\_\_\_\_  
80 to 100% of personal best

**Asthma Symptoms**

- No Cough, wheeze or shortness of breath
- Able to do all normal activities including exercise and play
- No symptoms at night
- No need for quick relief medications for symptoms

Use daily controller medications.

Use quick relief inhaler before exercise as ordered.

\*Peak flows may be obtained by the school RN in the health room.

**YELLOW ZONE**

\*Peak Flow \_\_\_\_\_  
50 to 80% of personal best

**Asthma Symptoms**

- Coughing, wheezing, shortness of breath, or chest tightness
- Using quick relief medication more than usual
- Can do some but not all of usual activities
- Asthma symptoms at night

**Take Quick Relief Medication Now!**

Add or change these medications:

Name of medication \_\_\_\_\_ How much \_\_\_\_\_ How often \_\_\_\_\_

Parent/guardian-call medical provider if using quick relief medication more than twice a week or no symptom improvement.

**RED ZONE**

\*Peak Flow \_\_\_\_\_  
Less than 50% of personal best

**Asthma Symptoms**

- Medication unavailable or not working
- Getting worse not better
- Breathing hard and fast
- Chest/neck pulling in
- Difficulty walking or talking
- Lips or fingernails blue
- Hunched over to breathe

**Take Quick Relief Medication Now!**

**Call 911 & continue to give Quick Relief Medication every 20 minutes until EMS arrives!**

Contact Parent & Provider-See Below

**Student can self carry medication?** Yes  No  **Student can self-administer medication?** Yes  No

Provider signature \_\_\_\_\_ Date \_\_\_\_\_ Provider printed name \_\_\_\_\_

Provider phone \_\_\_\_\_ Provider fax \_\_\_\_\_ Provider email \_\_\_\_\_

Parent/Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Work phone \_\_\_\_\_

School Nurse signature \_\_\_\_\_ Date \_\_\_\_\_ Phone \_\_\_\_\_