ASTHMA ACTION PLAN FOR SCHOOL

PARENT/GUARDIAN: Please complete **Student Information** and sign **Consent** below.

Student Name:	Date of Birth:	Grade:	Homeroom:	PICTURE OF STUDENT
Health Care Provider Name/Title:	Clinic:		Phone:	
Parent/Guardian:	Home:	Work:	Cell:	
Parent/Guardian:	Home:	Work:	Cell:	
Emergency Contact:	Home:	Work:	Cell:	

Allergies (food, medication, etc.):

Other Health Problems:

Asthma Triggers *(things that make asthma worse)* Check all that apply:

_ Exercise _Illness _Smoke _Pollen _Dust _Strong Odors _ Mold/Moisture _Stress/Emotions

_Animals, specify _Season: Fall, Winter, Spring, Summer _Other: ___________________________

Date of Last Flu Shot ___/___/___

REMINDER: GET A FLU SHOT

HEALTH CARE PROVIDER: Please complete **Asthma Severity**, **Zone Information**, **Medical Orders**, and **Consent** below.

Asthma Severity: _ Intermittent _ Mild Persistent _ Moderate Persistent _ Severe Persistent

Restrictions or Activity Limitation:

GREEN ZONE

GOOD!

Look For These Signs

- No cough, wheeze, nor difficulty breathing
- Can sleep through the night
- Can do usual activities
- **Peak flow is more than 80% of your personal best (___)**

What You Should Do

- Take your DAILY CONTROLLER MEDICINE at home every day *(if prescribed, see below).*
- **Take __________ inhaler ___ puffs at least ___ minutes before exercise.**
- Avoid things that make your asthma worse
- **Personal Best Peak Flow: (_____)**

INHALER IS KEPT:

- ☐ **With Student**
- ☐ **In Nurse's Office**
- ☐ **In Classroom # ____**
- ☐ **Other ________________**

YELLOW ZONE

CAUTION!

Look For These Signs

- Cough, wheeze, short of breath
- Waking at night due to wheeze or cough
- Can do some, but not all, usual activities
- **Peak flow is between 60% to 80% of your personal best (___ to ___)**

What You Should Do

DO NOT LEAVE STUDENT ALONE!

- Keep taking your DAILY CONTROLLER MEDICINE
- Begin using your QUICK-RELIEF MEDICINE *(see below).*
- Call parent/guardian
- **If better within 15-20 minutes, then repeat QUICK-RELIEF MEDICINE as listed every __ hours for __ days.**
- **If not in GREEN ZONE within 15-20 minutes, take __ puffs OR __ nebulizer treatment.**
- **If symptoms are not better or if peak flow is not improved, go to RED ZONE.**
- Call health care provider if using QUICK-RELIEF MEDICINE more than 2 times per week

RED ZONE

DANGER!

Look For These Signs

- Very short of breath
- Quick-relief medicine not helping
- Hard time walking or talking
- Skin around neck or between ribs pull in
- Blue lips or fingernails
- **Peak flow is less than 60% of your personal best (___)**

What You Should Do

DO NOT LEAVE STUDENT ALONE!

- Call 911
- Call School Nurse and/or Administrator (Report location & problem)
- **Take __ puffs of your QUICK-RELIEF MEDICINE OR __nebulizer treatment every ___ minutes until ambulance arrives!**
- Call parent/guardian

DAILY CONTROLLER MEDICINE

Medicine(s) Name	How Much to Take	How Often
		__ times per day EVERY DAY!
		__ times per day EVERY DAY!

QUICK-RELIEF MEDICINE

Medicine(s) Name	How Much to Take	How Often
☐ Albuterol	☐ 2 puffs	Take ONLY as needed (see above—starting in YELLOW ZONE)
☐ Levalbuterol	☐ 4 puffs	
☐ ___________	☐ 1 nebulizer treatment	

HEALTH CARE PROVIDER ORDER & MEDICATION CONSENT

Check all that apply:

- ☐ Student has been instructed in the proper use of his/her asthma medication(s) and is able to carry and self-administer his/her inhaler at school.
- ☐ Student is to notify the school nurse/designated school personnel after using inhaler at school.
- ☐ Student needs supervision or assistance when using inhaler.
- ☐ Student is unable to carry his/her inhaler while at school.

My signature provides authorization for the written orders in this Asthma Action Plan.

PARENT/GUARDIAN CONSENT

I, __________________________(parent/guardian), of the above named student, approve of this Asthma Action Plan. I give my permission for the school nurse and trained school personnel to follow this plan, administer medication(s), and contact my provider, if necessary. **I assume full responsibility for providing the school with prescribed medication(s) and/or monitoring device(s)/equipment(s).** I give my permission for the school nurse to share the above information with school staff that need to know and permission for my child to participate in any asthma educational learning opportunities at school.

Health Care Provider Signature/ Title:	Date:	Parent/Guardian Signature:	Date:
School:		School Address:	

School Health Counselor Signature/ Title:	Date:	Phone: