# Asthma Action Plan

DATE: ____ /____ /____ PATIENT NAME _____

WEIGHT: _____ PARENT/GUARDIAN NAME _____ PHONE _____

HEIGHT: _____ PRIMARY CARE PROVIDER/CLINIC NAME _____ PHONE _____

DOB: ____ /____ /____ WHAT TRIGGERS MY ASTHMA _____

**Baseline Severity**

**Best Peak Flow**

Always use a **holding chamber/spacer with / without** a mask with your inhaler. *(circle choices)*

## GREEN ZONE — DOING WELL — GO!

**You have ALL of these:**
- Breathing is good
- No cough or wheeze
- Can work/play easily
- Sleeping all night

**Peak Flow** is between: _____ **and** _____

*80-100% of personal best*

**Step 1:** Take these controller medicines every day:

| MEDICINE | HOW MUCH | WHEN |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Step 2:** If exercise triggers your asthma, take the following medicine **15 minutes before** exercise or sports.

| MEDICINE | HOW MUCH |
|---|---|
| | |

## YELLOW ZONE — GETTING WORSE — CAUTION

**You have ANY of these:**
- It's hard to breathe
- Coughing
- Wheezing
- Tightness in chest
- Cannot work/play easily
- Wake at night coughing

**Peak Flow** is between: _____ **and** _____

*50-79% of personal best*

**Step 1:** Keep taking **GREEN ZONE** medicines and **ADD** quick-relief medicine:

_____ *puffs or 1 nebulizer treatment of* _____

*Repeat after 20 minutes if needed (for a maximum of 2 treatments).*

**Step 2:** Within 1 hour, if your symptoms aren't better or you don't return to the **GREEN ZONE,** take your **oral steroid** medicine _____ **and** call your health care provider today.

**Step 3:** If you are in the **YELLOW ZONE** **more than 6 hours,** or your symptoms are **getting worse**, follow **RED ZONE** instructions.

## RED ZONE — EMERGENCY — GET HELP NOW!

**You have ANY of these:**
- It's very hard to breathe
- Nostrils open wide
- Ribs are showing
- Medicine is not helping
- Trouble walking or talking
- Lips or fingernails are grey or bluish

**Peak Flow** is between: _____ **and** _____

*Below 50% of personal best*

**Step 1:** Take your quick-relief medicine **NOW:**

| MEDICINE | HOW MUCH |
|---|---|
| | |

*or 1 nebulizer treatment of* _____

**AND**

**Step 2:** Call your health care provider **NOW**

**AND**

Go to the emergency room **OR** CALL **911** immediately.

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_____ This Asthma Action Plan provides authorization for the administration of medicine described in the AAP.

_____ This child has the knowledge and skills to self-administer quick-relief medicine at school or daycare with approval of the school nurse.

DATE: ____ /____ /____ MD/NP/PA SIGNATURE _____

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This consent may supplement the school or daycare's consent to give medicine and allows my child's medicine to be given at school/daycare.
My child *(circle one)* **may / may not** carry, self-administer and use quick-relief medicine at school with approval from the school nurse *(if applicable)*.

DATE: ____ /____ /____ PARENT/ GUARDIAN SIGNATURE _____

FOLLOW-UP APPOINTMENT IN _____ AT _____ PHONE _____

**ISD 318 Asthma Action Plan**

School Year: _____

This **student** is being treated for **Asthma**, the information below should assist you if the student has asthma symptoms during school hours.

**Student's Name**: _____ ***Date of Birth***: _____

Parent/Guardian: _____ Phone: _____

**ISD 318 recommends all students carry their inhalers at all times unless otherwise directed by parent/guardian or MD due to age constraints.**

If your child:

- does not respond the medication the MD has ordered **911 will be called**
- does not have his/her inhaler with them at all times during the school day as recommended and experiences asthma symptoms **911 may be called**

**Please note:**

- Prescription Medication(s) will only be given with written parent permission and written orders from your Healthcare Provider.
- Please notify the nurse if there are any changes made in the medication to be given (dosage change, discontinued, hold, etc.) A new order will be needed to make changes especially if a new medication is prescribed.
- **Your signature on this form also serves as a release for the nurse to exchange information with the Health Care Provider (via fax, telephone, or written) and appropriate school staff regarding medication and health issues/concerns. This information is private data and will be kept confidential.**
- I release the school personnel from any liability in relation to this request when the medication is given as ordered. I understand the school is rendering a service and does not assume any responsibility for this matter. I understand that a school nurse or designated person will administer the medication.
- Please notify the nurse of all the medication your child is taking even if they are taking it at home. This is important in case of an emergency.

Parent Signature:_____ Date:_____ ☐

**Completed parent portion of the Asthma Plan/ parent understands above statements and agrees.** Nurse signature: _____ Date/Time phone review: _____

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