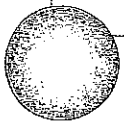


# Asthma Action Plan for Schools and Families

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
 Date of Birth (mm/dd/yyyy): \_\_\_\_\_ Medical Record #: \_\_\_\_\_  
 School Name: \_\_\_\_\_ School Contact Phone #: \_\_\_\_\_  
 Parent/Guardian Name: \_\_\_\_\_ Parent/Guardian Phone #: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Emergency Phone #: \_\_\_\_\_  
 Health Care Provider Name: \_\_\_\_\_ Health Care Provider Phone #: \_\_\_\_\_

To be completed by health care provider: Asthma Severity:  Mild Intermittent  Mild Persistent  Moderate Persistent  Severe Persistent  
 Attention Parent/Guardian/School Personnel: ANY student with asthma (of any severity) can have a severe asthma attack.  
 Asthma symptoms are triggered by:  Exercise  Dust  Animal dander  Strong Odors or Fumes  Mold  \_\_\_\_\_

**Green Zone** Personal Best Peak Flow (PF) \_\_\_\_\_ Date: \_\_\_\_\_  
 Peak flow is between \_\_\_\_\_ (80% of personal best) and \_\_\_\_\_ (100% of personal best)

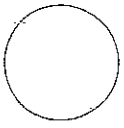


**1. Take CONTROLLER medication(s) (at home) EVERY DAY:**

Take \_\_\_\_\_ inhaler \_\_\_\_\_ puffs \_\_\_\_\_ times/day.  
Name of Medicine How much How often  
 Take \_\_\_\_\_ inhaler \_\_\_\_\_ puffs \_\_\_\_\_ times/day.  
Name of Medicine How much How often  
 If asthma is triggered by exercise, take  Albuterol or \_\_\_\_\_ inhaler \_\_\_\_\_ puffs at least \_\_\_\_\_  
Name of Medicine How much  
 minutes before exercise. Restrictions or activity limitations: \_\_\_\_\_

**Yellow Zone-Caution! DO NOT LEAVE STUDENT ALONE!**

Peak flow is between \_\_\_\_\_ (50% of personal best) and \_\_\_\_\_ (80% of personal best).



**1. Begin QUICK RELIEF medication (at school or home) right NOW:**

Take  Albuterol or \_\_\_\_\_ inhaler \_\_\_\_\_ puffs OR \_\_\_\_\_ solution \_\_\_\_\_ ml by nebulizer.  
Name of Medicine How much Name of Medicine How much  
 If symptoms are better or if the peak flow is back in the *Green Zone* within  15 minutes/ \_\_\_\_\_ minutes, THEN repeat QUICK RELIEF MEDICATION (as listed above in 1) every \_\_\_\_\_ hours.  
 If symptoms are NOT better or if the peak flow is NOT improved, go to Red Zone.  
 Attention School: Call Parent/Guardian when quick relief medication has been administered by student and/or staff.  
**2. Attention Parent/Guardian (Home Instructions):**  
 Call your child's Health Care Provider  
 Continue to take CONTROLLER medication (at home) everyday as written above in *Green Zone* instructions.  
 Increase CONTROLLER medication:  
 Take \_\_\_\_\_ inhaler \_\_\_\_\_ puffs \_\_\_\_\_ times/day.  
Name of Medicine How much How often

**Red Zone-Medical Alert! Get Help! DO NOT LEAVE STUDENT ALONE!** Peak flow is below \_\_\_\_\_ (50% of personal best).



**1. Take QUICK RELIEF medication (at school or home) right NOW:**

Take  Albuterol or \_\_\_\_\_ inhaler \_\_\_\_\_ puffs OR \_\_\_\_\_ solution \_\_\_\_\_ ml  
Name of Medicine How much Name of Medicine How much  
 by nebulizer and REPEAT EVERY 20 MINUTES UNTIL PARAMEDICS ARRIVE!  
 • Call 9-1-1 immediately and call Parent/Guardian  
**2. Attention Parent/Guardian (Home Instructions):**  
 Call your child's Health Care Provider.  Continue CONTROLLER medication (at home):  
 Take \_\_\_\_\_ inhaler \_\_\_\_\_ puffs \_\_\_\_\_ times/day.  
Name of Medicine How much How often  
 And ADD \_\_\_\_\_ mg orally once daily for \_\_\_\_\_ days.  
Name of Medicine How much Number

Authorization from Parent/Guardian: I have read and signed the attached *Authorization Form* so my child's Health Care Provider can share important information about my child's asthma to his/her school. My child is able to carry and self-administer asthma medications: Yes  No

\_\_\_\_\_  
Parent/Guardian Signature Date

Health Care Provider: My signature provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. Student is able to self-administer asthma medications: Yes  No  (This authorization is for a maximum of one year from signature date.)

\_\_\_\_\_  
Healthcare Provider Signature Date