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 _____ (Name of Medicine) inhaler _____ (How much) puffs _____ (How often) times/day.

Take _____ (Name of Medicine) inhaler _____ (How much) puffs _____ (How often) times/day.

If asthma is triggered by exercise, take ☐ Albuterol or _____ (Name of Medicine) inhaler _____ (How much) puffs at least _____ 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 _____ (Name of Medicine) inhaler _____ (How much) puffs OR _____ (Name of Medicine) solution _____ (How much) ml by nebulizer.

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 _____ (Name of Medicine) inhaler _____ (How much) puffs _____ (How often) times/day.

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 _____ (Name of Medicine) inhaler _____ (How much) puffs OR _____ (Name of Medicine) solution _____ (How much) ml 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 _____ (Name of Medicine) inhaler _____ (How much) puffs _____ (How often) times/day.

☐ And ADD _____ (Name of Medicine) _____ (How much) mg orally once daily for _____ (Number) days.

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)