Asthma Action Plan

The following is to be completed by the PHYSICIAN:

Student _____ School _____

Date of Birth _____ Today's Date _____

1. **Asthma severity:** (check one)

○ Mild intermediate ○ Mild persistent ○ Moderate persistent ○ Severe persistent

2. **Medications:** (at school and home)

	Medication Name	MDI, Oral, Neb	Dosage or Number of Puffs
Quick-Relief			
Routine			
Before PE / Exertion			

3. **For students on inhaled medications:** (all students must go to health office for oral medications)

○ Assist student with medication in office
○ Remind student to take medication
○ May carry own medication if responsible

4. **Check Known Triggers:**

○ Tobacco ○ Pesticide ○ Animals ○ Birds
○ Cleansers ○ Car exhaust ○ Perfume ○ Mold
○ Cold air ○ Stress ○ Exercise ○ Cockroach
○ Dust ○ Other: _____

5. **Peak Flow:** To determine yellow and red zone values, multiply by .8 and .5, respectively

100% GREEN ZONE
Peak Flow: _____

No Symptoms

80% YELLOW ZONE
Peak Flow: _____

Symptoms: Starting to cough, wheeze or feel short of breath.
Action for home or school: Give quick-relief medicine; notify parent
Action for Parent/MD: Increase controller dose

50% RED ZONE
Peak Flow: _____

Symptoms: Cough, short of breath, trouble walking or talking
Action for home or school: Take quick-relief medicines; notify parent. If student improves to yellow zone, send student to doctor or contact doctor. If student stays in red zone, begin Emergency Plan.

School Emergency Plan:
If a student has:

a. No improvement 15-20 minutes AFTER initial treatment with quick-relief medication
b. Peak flow of <50% of usual best
c. Trouble walking, or talking, or
d. Chest/neck muscle retractions with breaths, has a hunched appearance, or has a blue color
   1. Give quick-relief meds; repeat in 20 minutes, if help has not arrived
   2. Seek emergency care (911)
   3. Contact Parents

In Yellow or Red Zone? Students whose symptoms necessitate the use of quick-relief meds sometimes need to have an adjustment made to their prescription treatment plan. Schools must be sure parent is aware of each occasion when student had symptoms and requires medication.

*Physicians Name: (print) _____

Signature: _____ Date: _____

Office Address: _____

Office Telephone: _____

*(includes nurse practitioner or other health care provider as long as there is authority to prescribe)

A form that permits school and health care provider to exchange information must accompany this form.

Parent / Guardian Signature:

Date: _____ Home Telephone: _____

Emergency Telephone Number(s) / Names of Contact:

_____