



ASTHMA ACTION PLAN

Student Name: _____ Wt: _____ DOB: _____

Parent/Guardian: _____

Home Ph: _____ Cell or Work Ph: _____

Address: _____

Parent/Guardian: _____

Home Ph: _____ Cell or Work Ph: _____

Address: _____

Emergency Contact: _____ Relationship: _____ Ph: _____

Asthma Care Provider: _____ Ph: _____

Asthma Care Clinic: _____ Fax: _____

Other Physician: _____ Ph: _____

Daily Asthma Management Plan

Identify the things which start an asthma episode (check all that apply):

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Animals | <input type="checkbox"/> Pollens | <input type="checkbox"/> Food: _____ |
| <input type="checkbox"/> Change in temperature | <input type="checkbox"/> Strong odors/fumes | _____ |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Respiratory infections | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Molds | | _____ |

Control of School Environment: (List any environmental control measures, pre-medications, and/or dietary restrictions that the student needs to prevent an asthma episode.)

Peak Flow Monitoring:

Personal best: _____

Monitoring times: _____

(Turn Over for Backside...)

Green Zone:
"Go! All Clear!"

- ✓ Breathing is easy
- ✓ Can play, work, & sleep without asthma symptoms

Peak Flow Range
(80%-100% of personal best)

_____ to _____

The GREEN ZONE means take the following medicine(s) every day.

Controller Medicine(s): _____

Dose: _____

Spacer used: _____

Take the following medicine if needed 10-20 minutes before sports, exercise, or any other strenuous activity.

Yellow Zone:
"Caution..."

- ✓ Wake up at night
- ✓ Cough or wheeze
- ✓ Chest is tight

Peak Flow Range
(80%-100% of personal best)

_____ to _____

The YELLOW ZONE means keep taking your Green Zone controller medicine(s) every day and add the following medicine(s) to help keep the asthma symptoms from getting worse.

Reliever Medicine(s): _____

Dose: _____

If beginning cold symptoms, call your doctor before starting oral steroids

Use Quick Reliever 2-4 puffs every 20 minutes for up to 1 hour, or use nebulizer once. If your symptoms are not better or you do not return to the GREEN ZONE after 1 hour, follow RED ZONE instructions. If you are in the Yellow zone for more than 12-24 hours, call your provider. If your breathing symptoms get worse, call your provider.

Red Zone:
"STOP! Medical Alert!"

- ✓ Medicine is not helping
- ✓ Nose opens wide to breathe
- ✓ Breathing is hard & fast
- ✓ Trouble walking
- ✓ Trouble talking
- ✓ Ribs show

Peak Flow Range
(80%-100% of personal best)

_____ to _____

The RED ZONE means start taking your Red Zone medicine(s), and call your doctor NOW! Take these medicine(s) until you talk with your doctor. If your symptoms do not get better and you can't reach your doctor, *go to the emergency room or call 911 immediately.*

Reliever Medicine(s): _____

Dose: _____

I give my permission for this Asthma Action Plan to be used by the following, and for them to share information with each other about my student's asthma for the current school year, so that they can work together to help my student manage his/her asthma. This plan, when signed and dated, may replace/supplement the school's previous asthma form, and allows my student's medicine(s) to be administered at school. (Check and list all that apply)

___ School/school Health Office: _____ ___ Clinic/hospital: _____

___ Daycare provider: _____ ___ Coach: _____

___ Teacher: _____

___ Student is allowed to carry & self-administer medications after approval of school nurse

Parent Signature _____ Date _____

MD/NP/PA Signature _____ Date _____

Revised Date: 01/18/2007