

# Asthma Action Plan

Date Completed \_\_\_\_\_

Name	Date of Birth	Grade/Teacher
Health Care Provider	Health Care Provider's Office Phone	Medical Record Number
Parent/Guardian	Phone	Alternate Phone
Parent/Guardian/Alternate Emergency Contact	Phone	Alternate Phone

## DIAGNOSIS OF ASTHMA SEVERITY

Intermittent  Persistent [  Mild  Moderate  Severe ]

## ASTHMA TRIGGERS (Things That Make Asthma Worse)

Smoke  Colds  Exercise  Animals  Dust  Food  
 Weather  Odors  Pollen  Other \_\_\_\_\_

### GREEN ZONE: GO!

Take These **DAILY CONTROLLER MEDICINES (PREVENTION)** Medicines **EVERY DAY**

#### You have ALL of these:

- Breathing is easy
- No cough or wheeze
- Can work and play
- Can sleep all night



- No daily controller medicines required
- Daily controller medicine(s): \_\_\_\_\_
- \_\_\_\_\_
- Take \_\_\_\_\_ puff(s) or \_\_\_\_\_ tablet(s) \_\_\_\_\_ daily.
- For asthma with exercise, ADD: \_\_\_\_\_, \_\_\_\_\_ puffs with spacer \_\_\_\_\_ minutes before exercise

**ALWAYS RINSE YOUR MOUTH AFTER USING YOUR DAILY INHALED MEDICINE.**

### YELLOW ZONE: CAUTION!

Continue **DAILY CONTROLLER MEDICINES** and **ADD QUICK-RELIEF** Medicines

#### You have ANY of these:

- Cough or mild wheeze
- Tight chest
- Shortness of breath
- Problems sleeping, working, or playing



- Take daily controller medicine if ordered and add this quick-relief medicine when you have breathing problems:
- \_\_\_\_\_ inhaler \_\_\_\_\_ mcg
- Take \_\_\_\_\_ puffs every \_\_\_\_\_ hours, if needed. Always use a spacer, some children may need a mask.
- \_\_\_\_\_ nebulizer \_\_\_\_\_ mg / \_\_\_\_\_ ml
- Take a \_\_\_\_\_ nebulizer treatment every \_\_\_\_\_ hours, if needed.
- Other \_\_\_\_\_

If quick-relief medicine does not HELP within \_\_\_\_\_ minutes, take it again and CALL your Health Care Provider

If using quick-relief medicine more than \_\_\_\_\_ times in \_\_\_\_\_ hours, CALL your Health Care Provider

**IF IN THE YELLOW ZONE MORE THAN 24 HOURS, CALL HEALTH CARE PROVIDER.**

### RED ZONE: EMERGENCY!

Continue **DAILY CONTROLLER MEDICINES** and **QUICK-RELIEF** Medicines and **GET HELP!**

#### You have ANY of these:

- Very short of breath
- Medicine is not helping
- Breathing is fast and hard
- Nose wide open, ribs showing, can't talk well
- Lips or fingernails are grey or bluish



- \_\_\_\_\_ inhaler \_\_\_\_\_ mcg
- Take \_\_\_\_\_ puffs every \_\_\_\_\_ hours, if needed. Always use a spacer, some children may need a mask.
- \_\_\_\_\_ nebulizer \_\_\_\_\_ mg / \_\_\_\_\_ ml
- Take a \_\_\_\_\_ nebulizer treatment every \_\_\_\_\_ hours, if needed.
- Other \_\_\_\_\_

**CALL HEALTH CARE PROVIDER AGAIN WHILE GIVING QUICK-RELIEF MEDICINE. If health care provider cannot be contacted, CALL 911 FOR AN AMBULANCE OR GO DIRECTLY TO THE EMERGENCY DEPARTMENT!**

### REQUIRED PERMISSIONS FOR ALL MEDICATION USE AT SCHOOL

**Health Care Provider Permission:** I request this plan to be followed as written. This plan is valid for the school year \_\_\_\_\_ - \_\_\_\_\_.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Parent/Guardian Permission:** I give consent for the school nurse to give the medications listed on this plan or for trained school staff to assist my child to take them after review by the school nurse. This plan will be shared with school staff who care for my child.

I consent to communication between the prescribing health care provider, the school nurse, and the school medical doctor necessary for asthma management and administration of this medication.

Signature \_\_\_\_\_ Date \_\_\_\_\_

### OPTIONAL PERMISSIONS FOR INDEPENDENT MEDICATION CARRY AND USE AT SCHOOL

**Health Care Provider Independent Carry and Use Permission:** I attest that this student has demonstrated to me that they can self-administer this rescue medication effectively and may carry and use this medication independently at school with no supervision by school personnel.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Parent/Guardian Independent Carry and Use Permission (If Ordered by Provider Above):** I agree my child can self-administer this rescue medication effectively and may care and use this medication independently at school with no supervision by school personnel.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**School Nurse:** The student has demonstrated the skills to carry & self-administer their rescue medication, including when to tell an adult if symptoms do not improve after taking medication.

Signature (RN) \_\_\_\_\_ Date \_\_\_\_\_