ASTHMA ACTION PLAN

Student Name______________________**School**_________________________**Grade**__________

Your child should have regularly scheduled asthma check ups and should be seen after any emergency room or hospital visit by their primary care provider. The child's provider is: name____________________________________ phone #____________________________

Other important instructions:

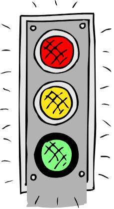
1. No smoking in your home or car, even if your child is not present
2. Always use a spacer with inhalers (MDIs) and rinse your child's mouth out after using inhaled steroids
3. Take measures to remove or control known triggers in your child's environment. Your child's triggers are:

☐ Respiratory infections or flu ☐ Mold ☐ Pollen ☐ Dust, dust mites
☐ Weather/temperature changes ☐ Indoor pets ☐ Exercise ☐ Strong odors or sprays
☐ Indoor/outdoor pollution ☐ Household cleaners ☐ Strong emotion ☐ Cockroaches
☐ Other allergies__________________.

4. It is the responsibility of the parent/guardian to provide medication.

GREEN ZONE – ALL CLEAR - GO		USE CONTROLLER MEDICINES

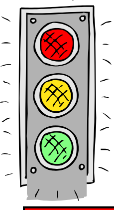
You are OK ☐ **No controller medicine needed at this time**



You should have:	Medicine	Method	How Much	How often
No wheezing				
No coughing	________________	_______	__________	_____times per day
No chest tightness	________________	_______	__________	_____times per day
No waking up at night because of Asthma	________________	_______	__________	_____________
No problems with play because of Asthma	________________	_______	__________	_____________
Peak flow number from _____ to _____	15 minutes before exercise use_____________			___puffs (Inhaled)

YELLOW ZONE – CAUTION! – TAKE ACTION	TAKE QUICK RELIEF MEDICINE

Asthma getting worse **Continue to use green zone daily medicines and add:**



You may have:	Medicine	Method	How much	How often
Coughing	____________	Inhaled	☐___puffs OR ☐____vial	Every ___hours
Wheezing	**Also take:**			
Chest Tightness	____________	______	____________________	____________

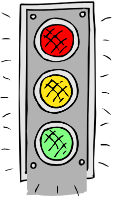
First signs of a cold
Coughing at night
Peak flow number from _____ to _____

If yellow zone symptoms continue for 24 hours, or they require extra rescue medication more than 2x per week, call your child's healthcare provider for further instructions. .

RED ZONE – STOP! – GET HELP NOW!		TAKE QUICK RELIEF MEDICINE

This is an emergency!

You may have:



Quick relief medicine that is not helping
Wheezing that is worse
Faster breathing
Blue lips or nail beds
Trouble walking or talking
Chest and neck pulled in with each breath
Peak flow less than ______________.

Continue to use green zone medicines and do the following:
Use _____ puffs or 1 vial Albuterol/Xopenex inhaled every 20 minutes for a total of _____ doses.`
Call the doctor now at ____________________for further instructions. If you cannot contact the doctor, go directly to the **Emergency Room or call 911**. DO NOT WAIT!!

Physician signature____ **Date**_____________________________________
Signature of Parent/Responsible Party:_____________________________________**Date:**____________________________________
School Health Nurse Signature ____**Date:**____________________________________

I, the parent of ___________________________, authorize the release and exchange of medical information between any of my child's health care providers and Hendricks Regional Health. I understand that this is for continuity of care purposes and may occur as needed without any prior notification or additional authorization throughout my child's care in the school system.

Parent/Guardian Signature ____**Date** ___________________________

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