Date of Plan: _____

Asthma Plan of Care

Form to be completed by Parents/Guardians and Child's Health Care Provider.
School Year _____

Student's Name _____ Date of Birth _____

Grade _____ Homeroom Teacher _____

Contact Information

Mother/Guardian _____

Telephone: Home _____ Work _____ Cell _____

Father/Guardian _____

Telephone: Home _____ Work _____ Cell _____

Student's Doctor/Health Care Provider:

Name _____

Address _____

Telephone _____ Emergency Number _____

Other Emergency Contacts:

Name _____ Relationship _____

Telephone: Home _____ Work _____ Cell _____

Name _____ Relationship _____

Telephone: Home _____ Work _____ Cell _____

Please remember to let your child's school know of any changes to the contact information as soon as possible.

Asthma Triggers and Interventions

Asthma Triggers (Identified items which may cause an asthma attack) *Check all that apply*

- ☐ Colds/infections
- ☐ Temperature Change
- ☐ Excitement
- ☐ Exercise – PE
- ☐ Food (Specify) _____
- ☐ Other (Specify) _____
- ☐ Strong Odors
- ☐ Pollen
- ☐ Dust
- ☐ Chalk Dust
- ☐ Tobacco smoke
- ☐ Smoke (Other than tobacco)
- ☐ Mold
- ☐ Cockroach
- ☐ Pets
- ☐ Mice/Rats
- ☐ Pesticides
- ☐ Dust Mites

Typical Signs and Symptoms – of asthma attacks *Check all that apply*

- ☐ Persistent Cough
- ☐ Wheezing
- ☐ Shortness of Breath
- ☐ Restlessness
- ☐ Other (Specify) _____
- ☐ Breathing faster
- ☐ Grunting
- ☐ Fatigue
- ☐ Flaring nostrils/panting
- ☐ Dark Circles under eyes
- ☐ Gray or blue lips/fingernails
- ☐ Sucking in of chest/neck
- ☐ Trouble talking/walking

Asthma Interventions with or without Peak Flow Meter Readings

Green Zone – Good Control	Treatment Plan
• No cough or wheeze • Tolerates activity easily Indicates the student's asthma is under good control This is where he/she should be every day. Peak flow **above** _____	1. Daily School Meds: *Check one* ☐ Albuterol ☐ Other _____ 2. ☐ Yes ☐ No Use before exercise/physical activity 3. Other _____

Yellow Zone- Worsening Asthma	Treatment Plan
• Cough, wheeze • More short of breath with activity • Need reliever inhaler often than usual Indicates a warning that student's asthma may flare unless additional measures are taken. **OR** •Peak Flow between _____ and _____	1. Reliever Inhaler: *Check one* ☐ Albuterol ☐ Other _____ 2. Recheck peak flow 10 minutes after treatment. May return to class if symptoms or peak flow improve. Vigorous activity should be avoided ☐Yes ☐ No **May repeat inhaler if no improvement in 20 min** 3. Call parents/guardians 4. If student is not improving or is getting worse, follow Red Zone Plan

Red Zone – Danger Zone	Treatment Plan
• Very Short of breath • Getting little/no relief from inhaler • Hard time walking or talking • Skin around neck or between ribs pulls in **OR** • Peak Flow **below** _____	1. Call parent/guardian to inform of situation 2. If symptoms continue to be severe and/or parents are not available call **7-911 *immediately*** 3. **Urgent Medications** _____ dosage _____ dosage

Signatures

This Asthma Medical Management Plan has been approved by:

_____ _____

Student's Physician/Health Care Provider Date

_____ _____

Student's Parent/Guardian Date