ASTHMA ACTION PLAN

Name: ____ DOB: ____________________

Asthma Severity	Allergies:		Other Triggers:		
☐ Intermittent	☐ Dust mites	☐ Animals	☐ Viral	☐ Weather	☐ Avoid asthma trigger(s)
☐ Mild persistent	☐ Mold	☐ Pollen	☐ Exercise	☐ Smoke	☐ No smoking in home or car
☐ Moderate persistent	Other:		Other:		☐ Inhaler technique reviewed
☐ Severe persistent	☐ Food allergies:				☐ Flu shot in Fall
	☐ Medication allergies:				

Green Zone: I feel good — Take CONTROLLER MEDICINE every day to control your asthma – this may include allergy medicine.

- Can work and play
- Can sleep at night
- No cough or wheeze

Peak Flow ________to ________
(80%-100% of Personal Best)

Medication	Dose			How Often
☐ Asmanex (mometasone)	☐ 110 mcg	☐ 220 mcg		___puff(s) ___ time(s) per day
☐ Flovent (fluticasone)	☐ 44 mcg	☐ 110 mcg	☐ 220 mcg	___puff(s) ___ time(s) per day
☐ Pulmicort Respules (budesonide)	☐ 0.25 mg	☐ 0.5 mg	☐ 1 mg	___ time(s) per day
☐ Pulmicort Flexhaler (budesonide)	☐ 90 mcg	☐ 180 mcg		___puff(s) ___ time(s) per day
☐ QVAR (beclomethasone)	☐ 40 mcg	☐ 80 mcg		___puff(s) ___ time(s) per day
☐ Advair Diskus (fluticasone/salmeterol)	☐ 100/50	☐ 250/50	☐ 500/50	1 puff twice daily
☐ Advair HFA (fluticasone/salmeterol)	☐ 45/21	☐ 115/21	☐ 230/21	2 puffs 2 times per day
☐ Dulera (mometasone/formoterol)	☐ 100 mcg	☐ 200 mcg		2 puffs 2 times per day
☐ Symbicort (budesonide/formoterol)	☐ 80/4.5	☐ 160/4.5		2 puffs 2 times per day
☐ Singulair (montelukast)	☐ 4 mg	☐ 5 mg	☐ 10 mg	daily

☐ Albuterol ☐ Xopenex (levalbuterol) 2 puffs 10-20 minutes before exercise and prior to exposure to triggers.

Additional orders:

Yellow Zone: I do not feel good — Keep taking Green Zone CONTROLLER MEDICINES. Take the following RELIEVER MEDICINES to keep asthma from getting worse.

- At first sign of cold with cough
- Wake up at night with cough
- Wheeze, tight chest, or trouble breathing

Peak Flow _______to_______
(50%-79% of Personal Best)

Medication	Dose			How often
☐ Albuterol Nebulizer	☐ 2.5 mg in 3 ml NS (premixed vial)			Every 4 hours
☐ Albuterol Inhaler	☐ 2 puffs			Every 4 hours
☐ Xopenex Nebulizer	☐ 0.31 mg	☐ 0.63 mg	☐ 1.25 mg	Every 4 hours
☐ Xopenex Inhaler	☐ 2 puffs			Every 4 hours

Additional orders:

Call or be seen if symptoms/peak flow are not improving after first 48 hours in the yellow zone, or if reliever medicine does not last 4 hours.

Red Zone: I feel awful — Take these medicines NOW and call your health care provider. KEEP TAKING the GREEN and YELLOW ZONE MEDICINES.

- Getting worse and meds not helping
- Breathing is hard and fast
- Coughs continuously

Peak Flow less than__________
(less than 50% of Personal Best)

Medication	Dose			How often
☐ Prednisone	_______mg			___tablet(s) ___ time(s) daily for 5 days
☐ Prednisolone Syrup	☐ 5 mg/5ml	☐ 15 mg/5ml		___ml ___ times(s) daily for 5 days
☐ Orapred disintegrating tablet(s)	☐ 10 mg	☐ 15 mg	☐ 30 mg	___tablet(s) ___ time(s) daily for 5 days

Increase above noted dose ☐ Albuterol ☐ Xopenex to every _________ hour(s)

Additional orders:

If breathing does not improve and you cannot immediately contact your health care provider, go to the emergency room.

Call 911 if:
- you can't talk in full sentences
- you can't get air
- fingernails or lips are grey or blue
- you are worried about getting through the next 30 minutes

Return to Clinic in: days _____weeks __________ months_____________ year

This form provides consent for school/day care to administer to my child the above medicine(s) as provided by parent or guardian and allows the child to carry the inhaler for which the provider has assessed ability and if approved by the school nurse. Plan given and reviewed with patient and/or parent.

Parent/Guardian signature ______________________ Date ______________

Health Care Provider signature ______________________ Date ______________ Clinic phone number ______________

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Edina Public Schools Asthma Action Plan
(This page to be completed by parent/guardian)

Student's Name:______________________________ School: ________________________________

School Year:_____________________

Parent/Guardian Authorization

1. I agree with the above Asthma Action Plan and I request that the above medication/s be given during school hours as ordered by my child's physician/licensed prescriber.
2. I request that the above medication be sent on field trips. ☐Yes ☐No
3. I will notify the school if medication is stopped.
4. I give permission for the medication/s to be given by school personnel as delegated, trained, and supervised by the licensed school nurse.
5. Legally I may refuse to sign the Asthma Action Plan. If I refuse to sign, the district will not be able to administer the prescribed medication.
6. This consent may be revoked at any time by sending a written notice to the licensed school nurse.

____ ____________________

Parent/Guardian Signature **Date**

Permission for Release of Information

1. I give permission for the school nurse to communicate, as needed with school staff about my child's medical condition/s and the action of the medication/s.
2. I give permission for the licensed school nurse to contact my child's physician/licensed prescriber regarding questions about the above listed medication/s or medical condition/s being treated by medication/s. If I do not give permission, the district may not be able to administer medication.

____ ____________________

Parent/Guardian Signature **Date**

Licensed School Nurse ____ Date ____________________

Health Associate ____ Date ____________________

For Licensed School Nurse Use

Trained personnel delegated to administer rescue inhaler

1. ____ Date: ____________________
2. ____ Date: ____________________