

Asthma Action Plan

Child's Name: _____ Birthdate: _____ Grade: _____ School: _____

The following is to be completed by the PHYSICIAN:

1. Asthma severity (circle one): mild intermediate _mild persistent _moderate persistent severe persistent

2. Medications (at school AND home):

A. <i>QUICK-RELIEF</i> Medication Name 1. _____ 2. _____	MDI, oral, neb?	Dosage or No. of Puffs _____
B. <i>ROUTINE</i> Med Name (eg, anti-inflammatory) 1. _____ 2. _____	MDI, oral, neb?	Dosage or No. of Puffs Time of day _____
C. <i>BEFORE PE, EXERTION</i> Medication Name 1. _____ 2. _____	MDI, oral, neb?	Dosage or No. of Puffs _____

3. For student on inhaled medication (all students must go to health office for oral medications):

Assist student with medication in office Remind student to take medication May carry own medication, if responsible

4. Circle Known Triggers: tobacco pesticide animals birds dust cleansers car exhaust perfume mold cockroach cold air
cleansers exercise Other: _____

5. Peak Flow: Write patient's personal best peak flow reading under the 100% box (below); multiply by .8 and .5, respectively

100%	Green Zone	80%	Yellow Zone	50%	Red Zone
Peak flow = _____	No Symptoms	Peak flow = _____	Starting to cough, wheeze or feel short of breath. <i>Action for home or school: Give quick-relief med; notify parent.</i> <i>Action for Parent/MD: Increase controller dose</i>	Peak flow = _____	Cough, short of breath, trouble walking or talking <u>Action for home or school:</u> <i>Take quick-relief meds;</i> <i>-If student improves to yellow zone, send student to doctor or contact doctor.</i> <i>-If student stays in red zone, begin Emergency Plan.</i>

School Emergency Plan: If student has: a) no improvement 15–20 minutes **AFTER** initial treatment with quick-relief medication, b) Peak flow of < 50% of usual best, c) trouble walking, or talking, or d) chest/neck muscle retractions with breaths, hunched, or blue color, then: 1) Give quick-relief meds; repeat in 20 minutes, if help has not arrived; 2) Seek emergency care (911); 3) Contact parent. **In yellow or red zone?** Students with symptoms who need to use quick-relief meds frequently may need change in routine controller medication. Schools must be sure parent is aware of each occasion when student had symptoms and requires medication.

Physician's[†] Name (print): _____ Signature: _____ Date: _____

Office Address: _____ Office Telephone: _____

[†]Includes nurse practitioner or other health care provider as long as there is authority to prescribe.

A form that permits school and health care provider to exchange information must accompany this form.

Parent/Guardian Signature: _____ Date: _____ Home Telephone: _____

Emergency Telephone Number(s) / Names of Contact: _____