Asthma Action Plan for Luxemburg-Casco School District

Name _____ **DOB** _____ /_____ /_____ **Grade**_____

TO BE COMPLETED BY PHYSICIAN:

Severity Classification ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Asthma Triggers (list) _____

Quick Relief Medication: _____medication _____puff(s)

☐ with ☐ without spacer every _____hours as needed.

Green Zone: Doing Well

Symptoms: Breathing is good – No cough or wheeze – Can do usual activity – No asthma symptoms with activity or rest

ACTIONS: Medicate if needed : ☐ with all activity

☐ when the child feels he/she needs it

Yellow Zone: Caution

Symptoms:Shortness of breath or difficulty breathing–Cough, wheeze, or chest tightness–Usual activity may be limited

ACTIONS: ☐ Administer quick relief medication.

The child should feel better within 15-20 minutes of the quick-relief treatment.

If the child is getting worse THEN follow the instructions in the RED ZONE and notify parents.

Red Zone: Get Help Now!

Symptoms: Difficulty talking with breathing between words– Medicine is not helping

ACTIONS: Take Quick-relief Medicine NOW!

☐ Albuterol/levalbuterol _____ puffs, every _____(frequency)

Call 911 immediately if the following danger signs are present:

-Trouble walking/talking due to shortness of breath
-Still in the red zone after 15 minutes
-Getting worse instead of better
-Lips or fingernails are blue
-Nose opens wider, nostrils flared

☐ It is my professional opinion that this child should be allowed to carry and use this inhaled medication as prescribed if needed prior to exercise or to alleviate asthma symptoms.

Healthcare Provider:

Name _____Date _____Phone (_____) _____-_____Signature_____

TO BE COMPLETED BY PARENT/GUARDIAN:

☐ I give permission for my child to **carry and self-administer** inhaled asthma medication if needed before exercise or to alleviate asthma symptoms as directed by his/her physician.

☐ I request that my child be **assisted by authorized school personnel** in taking the medication described above while at school.

Parent/Guardian:

Name _____Date_____Phone (_____) _____-_____Signature _____

I consent to communication between the prescribing health care provider/clinic and the school nurse as necessary for asthma management.