

# ASTHMA ACTION PLAN

Health Room Fax #: (704) 368-1078

## STUDENT

First: \_\_\_\_\_

Last: \_\_\_\_\_

DOB: \_\_\_\_\_ Grade: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Number: \_\_\_\_\_  
(other than parent)

→ PARENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

## PARENT

Parent's Names: \_\_\_\_\_

Father Cell: \_\_\_\_\_

Mother Cell: \_\_\_\_\_

## TO BE COMPLETED BY PHYSICIAN

TRIGGERS: \_\_\_\_\_ Pollen \_\_\_\_\_ Dust Mites \_\_\_\_\_ Smoke  
 \_\_\_\_\_ Exercise \_\_\_\_\_ Weather \_\_\_\_\_ Food  
 \_\_\_\_\_ Mold \_\_\_\_\_ Animals \_\_\_\_\_ Other:  
 \_\_\_\_\_ Cold/Flu \_\_\_\_\_ Air pollution \_\_\_\_\_

### ASTHMA SEVERITY CLASSIFICATION:

\_\_\_\_\_ Intermittent  
 \_\_\_\_\_ Mild Persistent  
 \_\_\_\_\_ Moderate Persistent  
 \_\_\_\_\_ Severe Persistent

EXERCISE PRE-TREATMENT: \_\_\_\_\_ Not required  
 \_\_\_\_\_ Before Recess (select treatment to the right) →  
 \_\_\_\_\_ Before P.E./Sports (select treatment to the right) →

GIVE THE STUDENT: Medicine: \_\_\_\_\_  
 How much: \_\_\_\_\_  
 \_\_\_\_\_ minutes prior to exercise

## GREEN ZONE - ALL CLEAR - GO! - ASTHMA IS WELL CONTROLLED

☐ If checked, no controlled medicine at this time.

Symptoms: • Breathing is easy  
 • No cough or wheeze  
 • Can do usual activities  
 • Can sleep through the night

☐ If checked, please monitor peak flow.  
 Peak flow from \_\_\_\_\_ to \_\_\_\_\_

MEDICINE	METHOD	DOSE	HOW OFTEN
			_____ times per day
			_____ times per day

## YELLOW ZONE - CAUTION - TAKEN ACTION - ASTHMA IS GETTING WORSE, Continue green zone daily medications and...

Symptoms: • Some shortness of breath  
 • Cough, wheeze or chest tightness  
 • Some difficulty doing usual activities  
 • Sleep disturbed by symptoms  
 • Symptoms of a cold or flu

☐ If checked, please monitor peak flow.  
 Peak flow from \_\_\_\_\_ to \_\_\_\_\_

MEDICINE	METHOD	DOSE	HOW OFTEN (circle one)
			Q _____ min/hr/day
			Q _____ min/hr/day

Alert parent to call doctor if yellow zone symptoms continue for 24 hours or if a child needs extra rescue medicine more than two times per week.

## RED ZONE - STOP! - GET HELP NOW - TAKE QUICK RELIEF MEDICINE

Symptoms: • Severe breathing problems  
 • Chest and neck pulled in with each breath  
 • Cannot do usual activities  
 • Difficulty walking or talking  
 • Rescue medicine is not helping

☐ If checked, please monitor peak flow.  
 Peak flow from \_\_\_\_\_ to \_\_\_\_\_ OR peak flow less than \_\_\_\_\_

### THIS IS AN EMERGENCY! CALL 911

Continue green zone medicines and do the following:

☐ \_\_\_\_\_ puffs of Albuterol/Xopenex - Q \_\_\_\_\_ min  
☐ one vial of Albuterol/Xopenex  
 Inhaled every 20 minutes for a total of \_\_\_\_\_ doses.

→ ☐ IF CHECKED STUDENT WILL SELF-CARRY INHALER. (Lower School students must supply emergency medicine to the health room.)  
 This student is capable and has been instructed in the proper method of self-administering medications named above. If checked this student will self carry emergency medicine throughout the school day and during all field trips. ALL middle and upper school students are responsible for self carrying emergency medicine during after school activities and overnight field trips, including sports, clubs, Winterim, Senior Trip and all summer activities/camps.) Student and/or parent will notify teachers, coaches, chaperones and school nurses emergency where medication will be located. All students are encouraged to provide an additional emergency medication to the health room.

→ PHYSICIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PHYSICIAN NAME PRINTED: \_\_\_\_\_ PHONE: \_\_\_\_\_

ALL MEDICATION WILL BE DISCARDED IF NOT PICKED UP BY THE LAST DAY OF SCHOOL.  
 THE ABOVE MEDICATION ORDER IS VALID FOR ONE YEAR FROM THE DATE SIGNED BY THE PHYSICIAN.