Bullard Independent School District

Asthma Action Plan

Place Student's Picture Here

Student's Name: _____ D.O.B. _____

Routine Medications: _____

_____

_____

● TRIGGERS ●

□Exercise □Emotions (when upset) □Cigarette smoke, smog, strong odors

□Colds (viral illnesses) □Irritants: Chalk dust, dust □Weather changes

□Molds □Pollens (trees, grasses, weeds) □Cold air weather changes

□Animal dander- Type _____ □ Dust and dust mites

□Other_____

● SYMPTOMS OF RESPIRATORY DIFFICULTY ●

□Coughing □Chest tightness □Shortness of breath □Turning blue

□Wheezing □ Shallow rapid breathing □Blueness of fingernails or lips

□Rapid, labored breathing

□Pulling in of skin around neck muscles, collar bone, between ribs and under breast

□Difficulty carrying on conversation due to breathing □Difficulty walking due to breathing

□Decreasing or loss of consciousness □Other _____

● INSTRUCTIONS FOR STAFF ●

■ Have student stop whatever they are doing

■ Send the student to the clinic when experiencing respiratory difficulty as described above

□ This student has been given permission to self-medicate with their inhaler. Please allow student to use inhaler according to the attached **AUTHORIZATION FOR SELF-CARRY/ADMINISTRATION OF MEDICATION AT SCHOOL** _____

Physician signature

● FIELD TRIPS ●

■ Medications and peak flow meter MUST accompany student on all field trips

■ A copy of this Action Plan and current phone numbers MUST be with staff member

■ Teacher must be instructed on correct use of asthma medications

● EMERGENCY CONTACTS ●

●Please give at least two contacts●

Name/Relationship	Phone Number 1	Phone Number 2
1.		
2.		
3.		
4.		

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Asthma Action Plan

ASTHMA INTERVENTION WITH OR WITHOUT PEAK FLOW METER READINGS

To be determined by Physician authorizing treatment

<<<GREEN ZONE>>> **Good Control**	<<<TREATMENT PLAN>>>
● No cough or wheeze ● Tolerating activity easily ● Peak flow above _____ Indicates the student's asthma is under good control. This is where he/she should be every day.	1. Daily school medication □ Yes □ No: _____ 2. Use before exercise/physical activity □ Yes □ No 3. Other _____

<<<YELLOW ZONE>>> **Worsening Asthma**	<<<TREATMENT PLAN>>>
● Worsening symptoms ● More short of breath with activity ● Need rescue inhaler more often than usual or peak flow between _____ & _____. Indicates a warning that a student's asthma may flare unless additional measures are taken	1. Rescue inhaler: _____ 2. Recheck peak flow 10 minutes after treatment. May return to class if symptoms and peak flow improve. Vigorous activity should be avoided. May repeat inhaler if no improvement in 20 minutes □ Yes □ No 3. **Call parent** and inform of situation. 4. If student is not improving or getting worse, follow RED ZONE plan.

<<<RED ZONE>>> **Danger Zone**	<<<TREATMENT PLAN>>>
● Getting little relief from inhalers or ● Peak flow below _____ ● More breathless despite increased medications. Peak flows do not respond to rescue inhaler/nebs. **This is student's danger zone.**	1. **Call parent** to inform of urgent situation. 2. If symptoms continue to be severe and/or parents aren't available call **911**. 3. Urgent Medications: _____ **Name/dosage/route**

- As parent/guardian of _____, I give permission for this plan to be available for use in my child's school, and for the nurse consultant to contact the named physician by phone, fax, or in writing when necessary to complete this plan.
- It is understood by the parent's and physician that this plan may be carried out by the school personnel other than the school nurse.
- This plan will be reviewed annually and/or whenever the health status or medications change and it is the responsibility of the parent to notify the school of these changes.

_____ _____

Physician's Signature Date Parent's Signature Date