Asthma Action Plan (2023-2024)

(Please Print) **School:**

Name	Date of Birth	Effective Date

Healthcare Provider Name:	Parent/Guardian Name:	Emergency Contact Name:
Healthcare Provider Phone Number/Fax number: /	Parent/Guardian Phone Number:	Emergency Contact Phone Number:

Asthma Severity
☐ Intermittent or
Persistent: ☐ Mild ☐ Moderate ☐ Severe
Asthma Control
☐ Well-controlled ☐ Needs better Control

Asthma Triggers Identified:
☐ Smoke ☐ Animals _____ ☐ Pests (rodents/cockroaches)
☐ Pollen ☐ Strong odors ☐ Stress/Emotions
☐ Dust ☐ Mold/Moisture ☐ Seasonal_____
☐ Exercise ☐ GERD ☐ Other:_____

***Personal best peak flow:_____**

Green Zone: Go!-Take these CONTROL (PREVENTION) medicines EVERY Day	
You have **ALL** of these: • Breathing is easy • No cough or wheeze • Can work and play • Can sleep all night **Peak flow in this area:**_____to _____ (More than 80% of personal best)	**Medications:**
Yellow Zone: Caution!-Continue CONTROL medicines and ADD QUICK-RELIEF medicines	
You have **ANY** of these: • Cough or mild wheeze • Tight Chest • Problems sleeping, working, or playing • Cough at night • Other:_____ **Peak flow in this area:**_____to _____ (50%-80% of Personal Best)	**Medications:**
Red Zone: EMERGENCY!Continue CONTROL & QUICK RELIEF medicines and GET HELP	
You have **ANY** of these: • Can't talk, eat, or walk well • Medicine is not helping • Breathing hard and fast • Blue lips and fingernails • Tired or lethargic • Nose opens wide • Ribs show when breathing **Peak flow is in this area: _____to_____** (less than 50% personal best)	**Medications:** **Contact your doctor! IF YOU CANNOT CONTACT YOUR DOCTOR: CALL 911 for an ambulance or go directly to the Emergency Department!**

Healthcare provider (printed)

Healthcare provider signature **Date**

Parent/Guardian name (printed)

Parent/Guardian signature **Date**

Exercise Induced Asthma Medication Order:

SCHOOL MEDICATION CONSENT AND PROVIDER ORDER FOR CHILDREN/YOUTH:
Possible side effects of quick-relief medications (ex. Albuterol) include tachycardia, tremor, and nervousness.
Healthcare provider (initial applicable option):
_____This student is capable and approved to self-administer the medicine(s) named above.
_____This student is not approved to self-medicate.
Parent/guardian (initial if applicable):
_____ I hereby authorize a trained school employee, if available, to administer medication to my child.
_____ I hereby acknowledge the student to possess and self-administer medications.