NAUGATUCK PUBLIC SCHOOLS

Asthma Action Plan

Name:	**Phone:**	**D.O.B.**
Provider:	**Provider Phone#:**	**Fax #:**
Patient Goal:		**Severity:**
Asthma Triggers: ☐ Exercise dust ☐ Pets ☐ Mold ☐ Smoke ☐ Pollen ☐ Viruses		

GO—You're Doing Well!

You have all of these:

- Breathing easy
- No cough or wheeze
- Sleep through the night
- Can work and play

OR

Peak Flow from Personal Best of

_____

to

_____

Use these medicines to prevent symptoms:

MEDICINE	HOW MUCH	HOW OFTEN/WHEN

CAUTION—Slow Down!

You have any of these:

- First signs of a cold
- Exposure to a known trigger
- Cough
- Mild wheeze
- Tight chest
- Coughing at night

OR

Peak Flow from

_____

to

_____

Continue with green zone medicine and add:

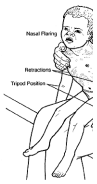
MEDICINE	HOW MUCH	HOW OFTEN/WHEN

For self carry/self administer students, if you use your inhaler in school, you MUST see your school nurse after you use your inhaler for evaluation of effectiveness.

DANGER—Get Help!

Your asthma is getting worse fast:

- Medicine is not helping
- Breathing is hard & fast
- Nose opens wide
- Ribs show
- Can't talk well



OR

Peak Flow Less Than

_____

Take these medicines & call your provider NOW!

MEDICINE	HOW MUCH	HOW OFTEN/WHEN

Your condition is serious & you need to get help NOW! Your provider will want to know about this—do not delay calling for help. If you cannot reach your provider right away, you must go to the Emergency Room or call 911 IMMEDIATELY!

Provider's Name _____ **Signature** _____ **Date** _____

Medication authorized from _____ to _____ **Child May Self-Administer?** Yes N

Parent/Guardian complete this section:

I hereby give permission to the school nurse to administer and to delegate the administration of the medications provided to the school as noted above. I also give permission to the school nurse and/or school-based clinic to exchange information and otherwise assist in the asthma management of my child including direct communication with my child's primary care provider. I have circled YES below if I believe my child can administer his/her own medicine.

Parent/Guardian Name _____ **Signature** _____ **Date** _____

Telephone Number: (H) _____ **(C)** _____ **Child May Self-Administer?** Yes No