School _____
Teacher _____

Sheldon Independent School District

Asthma Action Plan

Student's Name: _____ Date of Birth _____ Age_____ Grade _____
Guardian's Name _____ Phone # _____ Phone # _____
Guardian's Name _____ Phone # _____ Phone # _____
Emergency Contact _____ Relation_____ Phone # (s) _____
Physician/Health Care Provider _____ Phone number_____
How does the student get home? □Bus □ Car Rider □ Walker

I hereby authorize the school, through the nurse or principal designee, to give my child the necessary treatment as outlined below by the physician and to share information with other school staff members and health care providers on a need-to-know basis. I release Sheldon Independent School District, and any school district employee from any and all liability that may arise related to the treatment and/or care of my child as listed below.

Parent/Guardian's Signature: _____ **Date:** _____

To be Completed by Physician or Health Care Provider / Esta parte para ser completada por el MEDICO

Severity Classification: ❍ Mild Intermittent ❍ Mild Persistent ❍ Moderate Persistent ❍ Severe Persistent
Triggers: ❍ Colds ❍ Exercise ❍ Animals ❍ Smoke ❍ Dust ❍ Food ❍ Weather ❍ Air pollution ❍ Other _____
Exercise: Pre-medication:
_____

Green Zone: Doing Well **Peak Flow Meter Personal Best =** _____

Symptoms
- Breathing is good
- No cough or wheeze
- Can work and play
- Sleeps all night



Control Medications

Medicine	How much to Take	When to Take It
_____	_____	_____
_____	_____	_____

Peak Flow Meter: More than 80% of personal best or _____

Yellow Zone: Getting Worse **Contact Physician if using quick relief more than _____ times per week**

Symptoms
- Some problems breathing
- Cough, wheeze or chest tight
- Problems working or playing
- Wake at night

Continue control medicines and add:

Medicine	How much to Take	When to Take It
_____	_____	_____
_____	_____	_____

Peak Flow Meter
Between 50 to 80% of personal best or _____ to _____



IF your symptoms (and peak flow, if used) return to Green Zone after one hour of the quick relief treatment, THEN
- □ Take quick-relief medication every 4 hours for 1 to 2 days
- □ Change your long-term control medicines by _____
- □ Contact your physician for follow-up care

IF your symptoms (and peak flow, if used) DO NOT return to the GREEN ZONE after 1 hour of the quick relief treatment, THEN
- □ Take quick-relief treatment again
- □ Change your long-term control medicines by _____
- □ Call your physician within _____ hrs of modifying your medication routine

Red Zone: Medical Alert **Ambulance/Emergency Phone Number:** _____

Symptoms
- Lots of problems breathing
- Cannot work or play
- Getting worse instead of better
- Medicine is not helping

Peak Flow Meter
Between 0 to 50% of personal best or_____ to _____



Continue control medicines and add:

Medicine	How much to Take	When to Take It
_____	_____	_____
_____	_____	_____

Go to the hospital or call for an ambulance if
- □ Still in the red zone after 15 minutes
- □ If you have not been able to reach your physician/health care provider for help
- □ _____

Call an ambulance immediately if the following danger signs are present
- □ Trouble walking/talking due to shortness of breath
- □ Lips or fingernails are blue

Physician's Name _____ **Physician's Signature** _____ **Date** _____