PEARLAND INDEPENDENT SCHOOL DISTRICT

Asthma Action Plan

Student Name ____ **DOB** ____/____/____

Severity Classification ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Asthma Triggers (list) ____

Green Zone: Doing Well

Symptoms: Breathing is good – No cough or wheeze – Can work and play – Sleeps well at night

Control Medicine(s)	Medicine	How much to take	When and how to take it	Take at:
	________________	____________	______________________	☐ Home ☐ School
	________________	____________	______________________	☐ Home ☐ School

Physical Activity: Use albuterol _____ puff(s) 10-15 minutes before activity ☐ with all activity ☐ when child feels they need it

Yellow Zone: Caution

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

Quick-relief Medicine ☐ Albuterol_____ puffs every _____hours as needed ☐____ puffs every 20 minutes for up to 1 hour as needed OR nebulizer x1

Control Medicine(s) ☐ Continue Green Zone medicines

SMART as quick relief ☐ ICS/Formoterol _____ puff(s) with spacer ________________________ (how frequently)

(daily max dose 12 puffs for ages 12+yrs and 8 puffs for ages 4-11 yrs)

The child should feel better within 20–60 minutes of the quick-relief treatment. If the child is getting worse or is in the Yellow Zone for more than 24 hours, follow the instructions in the RED ZONE and call the doctor right away!

Red Zone: Get Help Now!

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

Take Quick-relief Medicine NOW! ☐ Albuterol/levalbuterol ______ puffs ________________________ (how frequently)

SMART as quick relief ☐ ICS/Formoterol _____ puff(s) with spacer ________________________ (how frequently)

Other Quick Relief Medicine: ☐ ____________________ _____ puffs ________________________ (how frequently)

Call 911 immediately if the following danger signs are present

- Trouble walking/talking due to shortness of breath
- Lips or fingernails are blue
- Still in the red zone after 15 minutes

If both the Healthcare Provider and the Parent/Guardian feel that the child has demonstrated the skills to carry and self-administer their quick- relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine, please **complete a separate self- administration authorization form**.

Healthcare Provider

Name ______________________________ Date ________ Phone (____) _____-______ Signature ____________________________

Parent/Guardian

I give permission for the medicines listed in the action plan to be administered in school by the nurse or other school staff as appropriate. I consent to communication between the prescribing health care provider or clinic, the school nurse, and school-based health clinic providers necessary for asthma management and administration of this medicine.

Name ______________________________ Date ________ Phone (____) _____-______ Signature ____________________________

School Nurse

I have reviewed the contents of this Asthma Action Plan and will communicate all relevant information to appropriate school personnel to ensure proper care and response to support the student's health and safety.

Name ______________________________ Date ________________ Signature ____________________________