VOLUSIA COUNTY SCHOOLS

VOLUSIA STUDENT SERVICES
Student Health Services

ASTHMA ACTION PLAN

Date: _____

Student Name: _____

Provider Name: _____ Emergency Contact Name & Phone Number: _____

Provider Phone Number: _____ Self-Carry: Yes ☐ No ☐

GREEN ZONE

DOING WELL

- No cough, wheeze, chest tightness, or shortness of breath during the day or night
- Can do usual activities.

And, if a peak flow meter is used,

Peak flow: more than (80 percent or more of my best peak flow)

My best peak flow is: _____

Daily Medications

Medicine	Dosage	When to take it

Before exercise: _____ ☐ 2 puffs ☐ 4 puffs ☐ 5 to 15 minutes before exercise

YELLOW ZONE

ASTHMA IS GETTING WORSE

- Cough, wheeze, chest tightness, or shortness of breath, or
- Waking at night due to asthma, or
- Can do some, but not all, usual activities

Or

Peak flow: ☐ to ☐ (50 to 79 percent of my best peak flow)

Add: quick-relief medicine – and keep taking your GREEN ZONE medicine

1st _____ (quick-relief medicine) ☐ Number of puffs ☐ Can repeat every ☐ minute(s)

or ☐ **Nebulizer, once** Up to maximum of ☐ doses.

2nd **If your symptoms (and peak flow, if used) return to GREEN ZONE after 1 hour of above treatment**

☐ Continue monitoring to be sure you stay in the green zone.

Or

If your symptoms (and peak flow, if used) do not return to GREEN ZONE after 1 hour of above treatment

☐ Take: _____ (quick-relief medicine) ☐ Number of puffs or ☐ Nebulizer, once

RED ZONE

MEDICAL ALERT!

- Very short of breath, or
- Quick-relief medicines has not provided relief.
- Cannot do usual activities, or
- Symptoms are same or get worse after 24 hours in Yellow Zone

Or

Peak flow: less than _____ (50 percent of my best peak flow)

Take this medicine:

☐ _____ (quick-relief medicine) ___ Number of puffs or ☐ Nebulizer, once

_____ mg

- You are still in the red zone after 15 minutes AND
- You have not reached the parent

DANGER SIGNS

Trouble walking and talking due to shortness of breath

Lips or fingernails are blue

Notify Parents/ Call 911

Take ☐ puffs of _____ (quick relief medicine)

AND _____ (phones)

Call 911 NOW!

Provider Signature/Date: _____ _____ Parent Signature/Date: _____ _____

RN Supervisor Signature/Date: _____ _____

TO BE COMPLETED BY VCS HEALTH SERVICES STAFF

Individualized Health Care Plan
Asthma

Student Name: _____ **Date of Birth:** _____

NURSING ASSESSMENT: Asthma – Assess for knowledge of asthma and knowledge of asthma triggers.

Dx Code: _____

NURSING DIAGNOSIS: **Potential for alteration in respiratory function/ Potential for self -care deficit related knowledge to of asthma and its complications.**

DESCRIPTION: Reversible condition of lungs with varying degrees of airway obstruction, broncho-spasm and accumulation of thick mucus within lung fields. Student may be absent from school frequently due to asthma or respiratory conditions. Student may experience chronic fatigue due to loss of sleep, if student has nighttime episodes of respiratory distress due to Asthma. Assess student for other physical education alternatives as needed.

GOALS: Student will attain and maintain near normal pulmonary function. The student will verbalize and demonstrate understanding of the use of inhalers and /or nebulizer. The student will verbalize understanding the avoidance of triggers.

SIGNS & SYMPTOMS: Wheezing, increased cough & difficulty in breathing. Rapid shallow respiratory rate may have inability to speak without pausing for breath, choking sensation, tightness in chest, chest pain, and feeling of suffocation, restlessness and anxiety.

MEDICATIONS: Follow Emergency Care plan as prescribed by medical provider.

INTERVENTIONS:

- Obtain medication orders, emergency care plan and authorization for asthma medication as indicated for management of condition.
- Administer medications as prescribed, nebulizer treatment if ordered; provide a cool, calm, quiet environment.
- Notify parent/guardian.
- Provide asthma related health education as needed.
- Instruct student in universal precautions and the care of a nebulizer. Instruct student on the proper use of inhalers or medication dispensing device.

OUTCOME/ COMMENTS: Notify parent /guardian as necessary.

Clinic Staff Signature	**Date**
RN Supervisor Signature	**Date**

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