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) taken at Home	Medicine	How much to take	When and how to take it
	_____	_____	_____
	_____	_____	_____

Physical Activity: Albuterol/levalbuterol _____ 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/Levalbuterol _____ puff(s) every _____ hours as needed

☐ Albuterol/Levalbuterol _____ puff(s) every 20 minutes for up to 1 hour OR Nebulizer (once)

Control Medicine: ☐ 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 getting worse, follow the instructions in the RED ZONE and call the doctor or 911 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 _____ puffs with spacer _____ (how frequently)

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

Call 911 immediately for these danger signs

- 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 _____