

Asthma Action Plan



General Information:

Name _____
 Emergency contact _____ Phone numbers _____
 Physician/healthcare provider _____ Phone numbers _____
 Physician signature _____ Date _____
 Parent signature _____ Date _____

Severity Classification	Triggers	Exercise
<input type="radio"/> Intermittent <input type="radio"/> Moderate Persistent <input type="radio"/> Mild Persistent <input type="radio"/> Severe Persistent	<input type="radio"/> Colds <input type="radio"/> Smoke <input type="radio"/> Weather <input type="radio"/> Exercise <input type="radio"/> Dust <input type="radio"/> Air Pollution <input type="radio"/> Animals <input type="radio"/> Food <input type="radio"/> Other _____	1. Premedication (how much and when) _____ 2. Exercise modifications _____

Green Zone: Doing Well	Peak Flow Meter Personal Best =														
Symptoms <input type="checkbox"/> Breathing is good <input type="checkbox"/> No cough or wheeze <input type="checkbox"/> Can work and play <input type="checkbox"/> Sleeps well at night	Control Medications: <table border="1"> <thead> <tr> <th>Medicine</th> <th>How Much to Take</th> <th>When to Take It</th> </tr> </thead> <tbody> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> </tbody> </table>			Medicine	How Much to Take	When to Take It	_____	_____	_____	_____	_____	_____	_____	_____	_____
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 2 times per week.														
Symptoms <input type="checkbox"/> Some problems breathing <input type="checkbox"/> Cough, wheeze, or chest tight <input type="checkbox"/> Problems working or playing <input type="checkbox"/> Wake at night	Continue control medicines and add: <table border="1"> <thead> <tr> <th>Medicine</th> <th>How Much to Take</th> <th>When to Take It</th> </tr> </thead> <tbody> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> </tbody> </table>			Medicine	How Much to Take	When to Take It	_____	_____	_____	_____	_____	_____	_____	_____	_____
Medicine	How Much to Take	When to Take It													
_____	_____	_____													
_____	_____	_____													
_____	_____	_____													
Peak Flow Meter Between 50% and 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 <input type="radio"/> Take quick-relief medication every 4 hours for 1 to 2 days. <input type="radio"/> Change your long-term control medicine by _____ <input type="radio"/> Contact your physician for follow-up care.	IF your symptoms (and peak flow, if used) DONOT return to Green Zone after one hour of the quick-relief treatment, THEN <input type="radio"/> Take quick-relief treatment again. <input type="radio"/> Change your long-term control medicine by _____ <input type="radio"/> Call your physician/Healthcare provider within _____ hour(s) of modifying your medication routine.													

Red Zone: Medical Alert	Ambulance/Emergency Phone Number:														
Symptoms <input type="checkbox"/> Lots of problems breathing <input type="checkbox"/> Cannot work or play <input type="checkbox"/> Getting worse instead of better <input type="checkbox"/> Medicine is not helping	Continue control medicines and add: <table border="1"> <thead> <tr> <th>Medicine</th> <th>How Much to Take</th> <th>When to Take It</th> </tr> </thead> <tbody> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> </tbody> </table>			Medicine	How Much to Take	When to Take It	_____	_____	_____	_____	_____	_____	_____	_____	_____
Medicine	How Much to Take	When to Take It													
_____	_____	_____													
_____	_____	_____													
_____	_____	_____													
Peak Flow Meter Less than 50% of personal best or _____ to _____	Go to the hospital or call for an ambulance if: <input type="radio"/> Still in the red zone after 15 minutes. <input type="radio"/> You have not been able to reach your physician/healthcare provider for help. <input type="radio"/> _____	Call an ambulance immediately if the following danger signs are present: <input type="radio"/> Trouble walking/talking due to shortness of breath. <input type="radio"/> Lips or fingernails are blue.													

(Self Carry and Self Administer apply only for EpiPen & Quick-relief Inhaler).

DAILY AS NEEDED SELF CARRY SELF ADMINISTER

FOR SELF CARRY/ADMINISTER ONLY

I certify that _____ is permitted to self administer the medication above. He/she understands the use for the medication and the necessity to report to school staff any unusual side effects. He/she is able to self carry and self administer the above independently. I indemnify and hold harmless the School District and its employees and agents, against any claims, except a claim based on willful and wanton conduct, arising out of self carry by the student.

FOR SELF CARRY ONLY

I certify that _____ is permitted to self carry, but not self administer, the medication above. I indemnify and hold harmless the School District and its employees and agents, against any claims, except a claim based on willful and wanton conduct, arising out of the student's self carry of the medication.

****ALL MEDICATIONS, BOTH OVER THE COUNTER OR PRESCRIPTION, NEED A PARENT AND A PHYSICIAN SIGNATURE.** All medications are required to be delivered by a parent/guardian, with the prescription label. All medications will be discarded 2 weeks after the last school day if not picked up. A new completed Medication Authorization Form is required at the beginning of every school year or when there is a change in the student's medical needs as indicated on this form.**