



Student Asthma Action Plan

Academic year: _____

Return to School _____

School Nurse Phone: _____ Fax _____

Name of Student _____ Age _____ Date of Birth _____

Teacher _____ Grade _____ Room Number _____

Asthma Care Physician	Phone Number
Other Physician	Phone Number

When my child is nearing an asthma episode, I notice the following signs (please circle all that apply):				
Runny/Stuffy Nose	Funny Feeling in Chest	Itchy Throat	Itchy Chest	Tummy Ache
Feeling Weak	Headache	Dry Mouth	Getting Upset	Nervous
Sad	Sneezing	Coughing	Watery Eyes	Circle Under Eyes
Other (please list):				
My child's asthma triggers (things that start an asthma attack) are (please circle all that apply):				
Animals With Fur	Dust	Cigarette Smoke	Strong Smells	
Cold Air	Humid Air	Colds	Sinus Infections	
Exercise (Running, Sports)	Aerosols (Hair Spray, Perfume)		Emotions (Sad, Happy)	
Cockroaches	Mold			
Food (please list): _____				
Other (please list): _____				

I have reviewed my child's action plan with the school nurse and believe all of the information to be accurate. I agree to notify the school nurse of any changes in my child's condition including emergency room visits and hospitalizations. I give the school nurse and my child's physician permission to contact one another or my insurance/Medicaid carrier for the purpose of obtaining information related to my child's health. A reasonable effort will be made to obtain the information from me prior to any other source.

Parent/Guardian Signature _____ Date _____

Please have your physician complete the 2nd side (Over).

Asthma Action Plan

To be completed by physician

Child's height _____

weight _____

POSSIBLE WARNING SIGNS	PEAK FLOW ZONES	TREATMENT PLAN												
<ul style="list-style-type: none"> ▪ sleeping without symptoms ▪ able to do normal activities without symptoms <p>OR</p> <ul style="list-style-type: none"> ▪ peak flow 80 to 100% of predicted or personal best <p>Student's personal best peak flow meter reading is: _____</p> <p>OR</p> <p>Student's predicted peak flow meter reading is: _____</p> <p style="text-align: center; font-weight: bold; font-size: 1.2em;">ALL CLEAR!</p>	<p style="font-weight: bold; font-size: 1.2em;">GREEN ALL CLEAR!</p> <p>_____ to _____</p> <p style="font-weight: bold;">Greater than 80% of Best of Predicted Peak Flow</p>	<p style="text-align: center; font-weight: bold;">Long-term Control - Daily Medications</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 33%; text-align: left;">Medicine</th> <th style="width: 33%; text-align: left;">How Much</th> <th style="width: 33%; text-align: left;">Frequency</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> <p>Before exercise: Take <input type="checkbox"/> 2 or <input type="checkbox"/> 4 puffs of _____</p> <p>_____ minutes before exercise.</p>	Medicine	How Much	Frequency	_____	_____	_____	_____	_____	_____	_____	_____	_____
Medicine	How Much	Frequency												
_____	_____	_____												
_____	_____	_____												
_____	_____	_____												
<p>Early warning signs of asthma may be seen:</p> <ul style="list-style-type: none"> ▪ cold symptoms and/or fever ▪ coughing/wheezing but able to do normal activities ▪ shortness of breath with activity ▪ chest tightness ▪ waking at night with cough/wheeze <p>OR</p> <ul style="list-style-type: none"> ▪ peak flow 50 to 80% of personal best <p style="text-align: center; font-weight: bold; font-size: 1.2em;">BE CAREFUL!</p>	<p style="font-weight: bold; font-size: 1.2em;">YELLOW CAUTION!</p> <p>_____ to _____</p> <p>50- 80% of Best of Predicted Peak Flow</p> <p>This is NOT where the student should be every day.</p> <p style="font-weight: bold; font-size: 1.2em;">TAKE ACTION</p>	<p style="text-align: center; font-weight: bold;">QUICK RELIEF - For Mild/Moderate Symptoms</p> <p>First Medicine: _____</p> <p><input type="checkbox"/> 2 or <input type="checkbox"/> 4 puffs or <input type="checkbox"/> by nebulizer one time</p> <p>Then: If improvement in 15 minutes: _____</p> <p>_____</p> <p>If no improvement in 15 minutes: _____</p> <p>_____</p>												
<p style="text-align: center;">This is an emergency, you need help!</p> <ol style="list-style-type: none"> 1. difficulty walking or talking 2. uses neck/stomach muscles when breathing 3. needs rescue medication more frequently than every 4 hours 4. constant coughing 5. worsening symptoms after treatments 6. blue or gray lips or fingernails <p>OR</p> <ol style="list-style-type: none"> 7. peak flow <50% of personal best <p style="text-align: center; font-weight: bold; font-size: 1.2em;">DANGER!</p>	<p style="font-weight: bold; font-size: 1.2em;">RED DANGER!</p> <p>Below _____</p> <p>Less than 50% of Best of Predicted Peak Flow</p>	<p style="text-align: center; font-weight: bold; font-size: 1.2em;">ALERT - For Severe Symptoms</p> <p>First, take this medicine: _____</p> <p><input type="checkbox"/> 2 or <input type="checkbox"/> 4 puffs or <input type="checkbox"/> by nebulizer one time</p> <p>If feeling better or repeat peak flow is in yellow zone, call doctor and ask for further instructions</p> <p>If no improvement or repeat peak flow is in red zone or nails or lips are blue or breathing is difficult:</p> <p style="text-align: center; font-weight: bold; font-size: 1.2em;">GO TO THE EMERGENCY ROOM OR CALL 911!!</p>												

Physician Signature _____

(Print & Sign)

Date _____

For School use only: Last reviewed on 11/02