**Rockford Public Schools**
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# ASTHMA ACTION PLAN FOR SCHOOL USE

Student: ______________________________________ Date of Birth: ____________________________

School: _______________________________________ Teacher/Advisor: _________________________ Grade: _______

Parent/Guardian Name: _________________________ Phone 1: ____________________ 2: ______________________

Best Peak Flow: _________L/min

Trigger(s): ☐ Colds/flu ☐ Exercise ☐ Allergens ☐ Odors ☐ Weather ☐ Foods ☐ Other:________________

***Actions for Asthma Episode:***

1. **Stop all activity immediately**
2. **Allow student to remain in position of comfort- usually sitting up**
3. **Use quick-relief medication as indicated on care plan below**
4. **Contact parents, school nurse, and/or 911 as needed**

## TO BE COMPLETED BY HEALTHCARE PROVIDER:

**Green Zone: Doing well**- breathing is good, no cough or wheezing - can work/play- sleeps well at night.

Peak Flow Meter: at or above _____L/min (more than 80% of personal best)

Control medication(s):

| Medication | Dose | When and how often |
|---|---|---|
| | | |
| | | |

Physical activity- Use albuterol/levalbuterol ____ puffs ☐ not required ☐ Before recess ☐ Before PE/Sports

**Yellow Zone: Caution**- some problems breathing- cough, wheeze, or chest tight - problems working/playing - wake at night- **Take actions to help prevent an emergency**. Peak Flow Meter: ___________L/min (50-79% of personal best)

Quick-relief medicine(s): ☐ Albuterol/levalbuterol ____ puffs, every 4 hours as needed

Control Medicine(s): ☐ Continue green zone medicine(s)

☐ Add ______________________________ ☐ Change to ____________________________

You should feel better within 20-60 minutes of quick-relief treatment. If worsening, follow instructions in Red zone.

**Red Zone: Emergency- Get Help Now** – very short of breath – quick-relief medication has not helped – cannot work/play Peak Flow Meter: less than _____ (less than 50% of personal best)

Take quick-relief medicine now ☐ Albuterol/levalbuterol ____ puffs, ___________________________(frequency)

Other: _______________________________________________________________________________

**<u>Call 911 immediately if the following signs are present:</u>**

- Trouble walking/talking due to shortness of breath
- Still in red zone 15 minutes after quick-relief medicine use
- Lips or fingernails are blue or grey
- Ribs showing or nose flaring

Physician signature: ___________________________________ Date: ____________________________

Printed name: ___________________________________________ Phone Number: __________________

*** A Medication Authorization Form must also be completed for all medications at school.

As parent/guardian of the above named student, I give permission for use of this health plan in my student's school and for the school nurse to discuss care with the above provider(s) regarding the above condition(s). Orders are valid through the end of the current school year. I will notify the school immediately if there is any change in treatment.

Parent Signature: ___________________________________ Date: _________________________