



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 a health care 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: _____

Call 911 immediately if the following signs are present:

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

Healthcare Provider signature: _____

Date: _____

Printed name: _____

Phone Number: _____

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: _____

***A Medication Authorization Form must also be completed for any medication used at school.