# Asthma Action Plan

AMERICAN LUNG ASSOCIATION.

**General Information:**

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

**Severity Classification**

- ○ Intermittent
- ○ Mild Persistent
- ○ Moderate Persistent
- ○ Severe Persistent

**Triggers**

- ○ Colds
- ○ Smoke
- ○ Weather
- ○ Exercise
- ○ Dust
- ○ Air Pollution
- ○ Animals
- ○ Food
- ○ Other _____

**Exercise**

1. Premedication (how much and when) _____
2. Exercise modifications _____

## Green Zone: Doing Well

**Peak Flow Meter Personal Best =**

**Symptoms**

- Breathing is good
- No cough or wheeze
- Can work and play
- Sleeps well at night

**Peak Flow Meter**

More than 80% of personal best or _____

**Control Medications:**

| Medicine | How Much to Take | When to Take It |
|---|---|---|
| | | |
| | | |
| | | |

## Yellow Zone: Getting Worse

**Contact physician if using quick relief more than 2 times per week.**

**Symptoms**

- Some problems breathing
- Cough, wheeze, or chest tight
- Problems working or playing
- Wake at night

**Peak Flow Meter**

Between 50% and 80% of personal best or _____ to _____

**Continue control medicines and add:**

| Medicine | How Much to Take | When to Take It |
|---|---|---|
| | | |
| | | |
| | | |

**IF your symptoms (and peak flow, if used) return to Green Zone after one hour of the quick-relief treatment, THEN**

- ○ Take quick-relief medication every 4 hours for 1 to 2 days.
- ○ Change your long-term control medicine by _____
- ○ Contact your physician for follow-up care.

**IF your symptoms (and peak flow, if used) DO NOT return to Green Zone after one hour of the quick-relief treatment, THEN**

- ○ Take quick-relief treatment again.
- ○ Change your long-term control medicine by _____
- ○ Call your physician/Healthcare provider within _____ hour(s) of modifying your medication routine.

## Red Zone: Medical Alert

**Ambulance/Emergency Phone Number:**

**Symptoms**

- Lots of problems breathing
- Cannot work or play
- Getting worse instead of better
- Medicine is not helping

**Peak Flow Meter**

Less than 50% of personal best or _____ to _____

**Continue control medicines and add:**

| Medicine | How Much to Take | When to Take It |
|---|---|---|
| | | |
| | | |
| | | |

**Go to the hospital or call for an ambulance if:**

- ○ Still in the red zone after 15 minutes.
- ○ You have not been able to reach your physician/healthcare provider for help.
- ○ _____

**Call an ambulance immediately if the following danger signs are present:**

- ○ Trouble walking/talking due to shortness of breath.
- ○ Lips or fingernails are blue.

- ☐ **Fennville Public Schools**
- ☐ **Hamilton Public Schools**
- ☐ **Holland Christian Schools**
- ☐ **Holland Public Schools**
- ☐ **West Ottawa Public Schools**

# School Nursing
# Asthma IHP

*Medications may be administered at school by school personnel when necessary for school attendance. This completed form, along with the medication and/or special equipment items are to be brought to the school by the parent/guardian.*

Photo

**TO BE COMPLETED BY PARENT / GUARDIAN**

I, the parent/guardian of _____date of birth_____ request that the building administrator or his/her designee administer the medication or procedure listed below as directed. I give my consent for the exchange of information between the school and my child's health care provider. I give permission to share, if necessary, this information with school personnel who may be involved with the welfare of my child. I fully realize I can withdraw my request/consent in writing at any future date.

As a parent, I understand my responsibilities are:

1. To provide the school with a supply of medication in the original container appropriately labeled by the pharmacy.
2. To provide the school with the written doctor's instructions for medication administration during school hours And that medication will not be administered until signed doctors instructions are at school.
3. To inform the school of any medical changes.
4. To provide the school with this signed consent form annually and when changes in medication occur.
5. I give permission for my child to self administer rescue medication if approved by physician

## Please complete attached asthma action plan from American Lung Association, or submit a current plan already on file in physician office.

Signature of Parent/Guardian: _____ Relationship: _____ Date: _____

Emergency Contact Phone Number _____

**OK for student to carry/self-administer prescribed inhaler: ☐Yes ☐No**

**Physician Signature:** _____ Date: _____

Physician's Name (printed): _____

Phone Number: _____ FAX Number: _____