

Asthma Action Plan for _____ School

Child's Name: _____ Date of Birth: _____
Parent/Guardian: _____ Parent/Guardian Phone: _____, _____
Health Care Provider: _____ Teacher: _____ Grade: _____

Asthma Severity: Rare episode (symptoms \leq than 1 x/ mos) Mild (symptoms \leq than 2 x's/wk)
 Moderate (symptoms \geq 3 x's/wk) Severe (symptoms daily during day and night)

ANY student with asthma (of any severity) can have a severe asthma attack.

Asthma symptoms are triggered by: Exercise Dust Animal Dander Strong Odors/Fumes Mold Other

Exercise induced: If asthma is triggered by exercise, child is to take _____ inhaler _____ puffs at least _____ minutes before exercise. Restrictions or activity limitations: _____.

USING SYMPTOMS TO KNOW THE CHILD'S ZONE

GREEN ZONE

Symptoms:

- ✓ no cough or wheeze during day or night
- ✓ No chest tightness
- ✓ Personal Best Peak Flow (PF) _____ Date _____

Treatment:

- ✓ No treatment indicated

YELLOW ZONE

Symptoms:

- ✓ Coughing or wheezing
- ✓ Chest tightness
- ✓ Problems playing, walking, or talking
- ✓ Shortness of breath

Treatment:

- ✓ Stay calm, speak reassuringly, provide privacy, and do not leave the child alone.
- ✓ Sit child upright. Do not let child lie down.
- ✓ Take _____ inhaler _____ puffs then repeat quick relief medication _____ every _____ hours as needed.
- ✓ If symptoms have not improved go to the Red Zone. Call parent/guardian immediately.

RED ZONE—MEDICAL EMERGENCY! GET HELP IMMEDIATELY! DO NOT LEAVE CHILD ALONE!

Symptoms:

- ✓ Persistent cough or wheeze
- ✓ Severe chest tightness
- ✓ Can not walk, talk, or move well
- ✓ Skin is pulled tightly around neck or chest (retractions)
- ✓ Blue skin color around lips or nails.

Treatment:

- ✓ Call 911 immediately
- ✓ Take quick relief medication right now if not already given (see yellow zone).
- ✓ Call parent/guardian

On (Date) _____, the above protocol was developed by (Name) _____, R.N., School Nurse, in conjunction with (Parent/Guardian) _____ following (Health Care Provider) _____'s written instruction on the School Medication Authorization Form dated _____.

Parent/Guardian Signature _____

Date _____