ASTHMA ACTION PLAN

Sponsored by the American Lung Association of Eastern Missouri

Student Name:_____Date: _____

Healthcare Provider: _____Phone: _____ Fax: _____

SECTIONS BELOW ARE TO BE COMPLETED BY HEALTHCARE PROVIDER

Green Zone

HEALTHY → YOU ARE OK! Take your daily control medicine(s) as prescribed below:

Medication	Dose	Frequency

You are in the GREEN ZONE when:

*Breathing is good
*No cough or wheeze
*Can work or play

Yellow Zone CAUTION! →Take 2puffs of your quick relief medicine NOW:

Medication	Dose	Frequency

You are in the YELLOW ZONE when:

*Getting hard to breath
*Chest tightness
*Mild wheeze

If no relief Take 1 Nebulizer Treatment of:

Medication	Dose	Frequency

Red Zone

DANGER! → Take □2 □4 □6 puffs of your quick relief medicine or □another Nebulizer Treatment **and** Call 911 or go to the nearest hospital!
May repeat treatment every 20 minutes until the paramedics arrive.

You are in the RED ZONE when:

*Medicine is not helping after 15-20 minutes
*Breathing is hard and fast
*Nose opens wide (flaring nostrils)
*Can't walk or talk well

Permission to Carry Rescue Medication

All rescue medication will be kept in the nurse's office unless permission to carry forms have been completed.

□ Board Form 2870 and Form 2870.1 have been completed and signed. Student is approved to carry, self-medicate, and will go to nurse's office to be evaluated.

□ Student is NOT approved to carry and will go to the nurse's office to get medication.

Physician Signature_____Date _____

Parent/Guardian Signature_____ Date_____

Asthma Assessment Form

Date:_____

Student Name: _____ **Grade**:____ **School Year**:_____

Gender: ☐M ☐F **Age**:____ **Height** _____cm **Race**: ☐White ☐Black ☐Asian ☐Hispanic ☐Other

Triggers (circle all that apply): Dust mites, molds, pollen, feathers, animal dander, cockroaches, cold, exercise, chemicals, sinus infections, cigarette smoke, exhaust, foods, yelling, crying, laughing, perfume, strong odors, other_____

Compliant ☐Y ☐N **Parent Ed**._____
Severity _____
☐Intermittent
☐ Persistent (☐Mild ☐Mod ☐Severe)
Control ☐Well ☐Not Well ☐Poorly
ER Visits ☐Y ☐N

Medications:
☐SABA_____
☐ICS_____
☐ICS/LABA_____
Aerochamber ☐ Y ☐N ☐School ☐Home
Date Given_____

Physician:_____ **Date: of Flu Vaccine**:_____

Personal Best: FEV1_____ PEF_____ Predicted: FEV1_____ PEF_____

Peak Flow Zones: FEV1 Red_____ Yellow_____ Green_____
(predicted) : PEF Red_____ Yellow_____ Green_____

Peak Flow Zones: FEV1 Red_____ Yellow_____ Green_____
(personal best) : PEF Red_____ Yellow_____ Green_____

In Check Dial

MDI Date_____ Pre Ed _____L/m Post Ed _____L/m

Diskus Date_____ Pre Ed _____L/m Post Ed _____L/m

☐**Note in SISK12** Date:_____

Comments:_____
_____
_____
_____
_____

Date	Time	FEV1	FEV1 %	PEF	PEF %	In check Pre	In check Post	Target Time	Comments