**GREAT HEARTS ACADEMY – ASTHMA ACTION PLAN** for the 2019/2020 SCHOOL YEAR

CHILD **LAST** NAME: ______________________________________
FIRST NAME: ________________________ DOB: ______________
PARENT/GUARDIAN: ___________________________________
BEST CONTACT PHONE NUMBER: ___________________________
PHYSICIAN NAME: ____________________________________
PHYSICIAN PHONE NUMBER: _____________________________
TEACHER: _____________________________ ROOM # __________

☐ ASTHMA TRIGGERS: EXERCISE STRONG ODORS OR FUMES RESPIRATORY INFECTIONS
ANIMALS DUST TEMPERATURE CHANGES POLLENS
MOLDS FOOD CARPET OTHER: ___________________________

Does your student use a peak flow monitor? ________yes ________no
Personal best peak flow number: ______________________________ Monitoring times during the day: _______________________

☐ DAILY PREVENTION/MANAGEMENT PLAN: *(Breathing is good, no cough or wheeze, can sleep through the night, can work and play OR other specific symptoms such as ____________________________________________)*

| CONTROLLER MEDICATION | DOSE | FREQUENCY | Given to school nurse? |
|---|---|---|---|
| | | | |
| | | | |

☐ BEGINNING SYMPTOMS: *(First signs of a cold, exposure to known trigger, cough, wheeze, chest tightness, coughing at night OR other specific symptoms such as ____________________________________________)*

| RESCUE MEDICATION | DOSE | FREQUENCY | Given to school nurse? |
|---|---|---|---|
| | | | |
| | | | |

1. Use the rescue medications listed above or ______________________________________________
2. Have student return to class if _____________________________________________________
3. Contact parent if _____________________________________________________________

☐ WORSENING SYMPTOMS: (*Medicine is not helping, breathing is hard and fast, nose opens wide, can't talk well, getting nervous OR other specific symptoms such as ____________________________________________)*

| EMERGENCY MEDICATION | DOSE | FREQUENCY | Given to school nurse? |
|---|---|---|---|
| | | | |
| | | | |

**Call 9-1-1** if the student

1. Shows no improvement in 15-20 minutes after the rescue and emergency treatments are used, and the above-mentioned parent-guardian cannot be reached
2. Difficulty breathing, walking or talking
3. Lips or fingernails are blue or gray or other ____________________________________________

I understand that school staff MUST be informed of my child's health concerns in order to provide safe and appropriate care. I will update the school nurse office as my child's health conditions/treatments change throughout the year.

Parent/Guardian signature: ____________________________________________________________ Date: ______________

American Lung Association Asthma Action Plan

# Asthma Action Plan

## General Information:

Name: ______________________________________________________________________________

Emergency contact: ______________________________________________ Phone number: __________________

Physician/Healthcare Provider: ________________________________________ Phone number: __________________

Physician Signature: _______________________________________________ Date: __________________________

| Severity Classification | Triggers | Exercise |
|---|---|---|
| ☐ Mild intermittent<br>☐ Mild persistent<br>☐ Moderate persistent<br>☐ Severe persistent | ☐ Colds<br>☐ Exercise<br>☐ Animals<br>Other: ________________________<br>☐ Smoke<br>☐ Dust<br>☐ Food<br>☐ Weather<br>☐ Air pollution | 1. Pre-medication (how much and when): ____________________ ________________________<br>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 all night

**Control Medications:**

| Medicine | How Much To Take | When To Take It |
|---|---|---|
| ______________________ | ______________________ | __________________ |
| ______________________ | ______________________ | __________________ |
| ______________________ | ______________________ | __________________ |

Peak Flow Meter
More than 80% of personal best or _________

## 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% to 80% of personal best or
__________ to ___________

**Continue control medications and add:**

| Medicine | How Much To Take | When To Take It |
|---|---|---|
| ______________________ | ______________________ | __________________ |
| ______________________ | ______________________ | __________________ |
| ______________________ | ______________________ | __________________ |

**IF your symptoms (peak flow, if used) return to Green Zone after 1 hour of the quick relief treatment, THEN:**
-Take quick-relief medication every 4 hours for 1 to 2 days
-Change your long-term control medicines by______________________
-Contact your physician for follow-up care

**IF your symptoms (peak flow, if used) DO NOT return to Green Zone after 1 hour of the quick relief treatment, THEN:**
-Take quick-relief treatment again
Change your long-term control medicines by ____________________
Contact your physician/ healthcare provider within ________hours 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**
Between 0% to 50% of personal best or
____________ to ____________

**Continue control medications and add:**

| Medicine | How Much To Take | When To Take It |
|---|---|---|
| ______________________ | ______________________ | __________________ |
| ______________________ | ______________________ | __________________ |
| ______________________ | ______________________ | __________________ |

**Go to hospital or call for an ambulance if:**
Still in the red zone after 15minutes
If you have not been able to reach your physician/ healthcare provider for help
_____________________________

**Call for an ambulance immediately if the following danger signs are present:**
Trouble walking/talking due to shortness of breath
Lips or fingernails are blue