American Academy of Allergy Asthma & Immunology

Asthma Action Plan for Home & School

Name: **Birthdate:**

Asthma Severity: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent
☐ He/she has had many or severe asthma attacks/exacerbations

☺ Green Zone
Have the child take these medicines every day, even when the child feels well.

Always use a spacer with inhalers as directed.

Controller Medicine(s): _____

_____

Controller Medicine(s) Given in School: _____

Rescue Medicine: Albuterol/Levalbuterol _____ puffs every four hours as needed

Exercise Medicine: Albuterol/Levalbuterol _____ puffs 15 minutes before activity as needed

😐 Yellow Zone
Begin the sick treatment plan if the child has a cough, wheeze, shortness of breath, or tight chest. Have the child take all of these medicines when sick.

Rescue Medicine: Albuterol/Levalbuterol _____ puffs every 4 hours as needed

Controller Medicine(s):

☐ Continue Green Zone medicines: _____

☐ Add: _____

_____

☐ Change: _____

If the child is in the **yellow** zone more than **24** hours or is getting worse, follow **red** zone and call the doctor right away!

☹ Red Zone
If breathing is hard and fast, ribs sticking out, trouble walking, talking, or sleeping.
Get Help Now

Take rescue medicine(s) now

Rescue Medicine: Albuterol/Levalbuterol _____ puffs every _____

Take: _____

_____

If the child is not better right away, call 911
Please call the doctor any time the child is in the red zone.

Asthma Triggers: (List)

School Staff: Follow the Yellow and Red Zone plans for rescue medicines according to asthma symptoms.
Unless otherwise noted, the only controllers to be administered in school are those listed as "given in school" in the green zone.

☐ Both the asthma provider and the parent feel that the child may carry and self-administer their inhalers
☐ School nurse agrees with student self-administering the inhalers

Asthma Provider Printed Name and Contact Information:	Asthma Provider Signature: Date:

Parent/Guardian: I give written authorization for the medications listed in the action plan to be administered in school by the nurse or other school members as appropriate. I consent to communication between the prescribing health care provider/clinic, the school nurse, the school medical advisor and school-based health clinic providers necessary for asthma management and administration of this medication.

Parent/guardian signature: Date:	School Nurse Reviewed: Date:

Please send a signed copy back to the provider listed above.

Asthma Action Plan

Student's name_____ **Class**____

Student's Address: _____

Emergency Contact #1_____Phone No._____

Emergency Contact #2_____Phone No._____

Daily Plan

When was this student diagnosed with asthma? _____

What symptoms of asthma does this student exhibit during an episode? (Please circle):

Feeling tightness in chest Wheezing Coughing

Labored breathing Other_____

Does this student recognize symptoms as an asthma episode? yes no

How often does student experience episodes? _____

What things start an asthma episode for this student? (Please circle)

Exercise	Strong odors or perfumes	Respiratory infections
Pollens	Chalk dust	Cold temperature
Molds	Animals _____	Humid weather
Carpets	Food _____	Other _____

List any environmental control measures, pre-medications, and/or dietary restrictions that the student needs to prevent an asthma episode at school _____

_____

_____

_____

Peak flow monitoring information (if needed)_____

Daily medication plan (include home medications)

	Name	Dose	When used
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Complete Both Sides of Form