

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: _____



Asthma Action Plan

General Information:

Name _____
 Emergency contact _____ Phone numbers _____
 Physician/Healthcare Provider _____ Phone numbers _____
 Physician Signature _____ Date _____

Severity Classification	Triggers	Exercise
<input type="radio"/> Mild Intermittent <input type="radio"/> Moderate Persistent <input type="radio"/> Mild Persistent <input type="radio"/> Severe Persistent	<input type="radio"/> Colds <input type="radio"/> Smoke <input type="radio"/> Weather <input type="radio"/> Exercise <input type="radio"/> Dust <input type="radio"/> Air pollution <input type="radio"/> Animals <input type="radio"/> Food <input type="radio"/> Other _____	1. Pre-medication (how much and when) _____ 2. Exercise modifications _____

Green Zone: Doing Well

Symptoms

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

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

Peak Flow Meter Personal Best =

Control Medications	How Much To Take	When To Take It
Medicine _____	_____	_____
_____	_____	_____
_____	_____	_____

Yellow Zone: Getting Worse

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 _____

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

Continue control medicines and add:	How Much To Take	When To Take It
Medicine _____	_____	_____
_____	_____	_____
_____	_____	_____

<p>IF your symptoms (and peak flow, if used) return to Green Zone after 1 hour of the quick relief treatment, THEN</p> <ul style="list-style-type: none"> <input type="radio"/> Take quick-relief medication every 4 hours for 1 to 2 days <input type="radio"/> Change your long-term control medicines by _____ <input type="radio"/> Contact your physician for follow-up care 	<p>IF your symptoms (and peak flow, if used) DO NOT return to the GREEN ZONE after 1 hour of the quick relief treatment, THEN</p> <ul style="list-style-type: none"> <input type="radio"/> Take quick-relief treatment again <input type="radio"/> Change your long-term control medicines by _____ <input type="radio"/> Call your physician/healthcare provider within _____ hours of modifying your medication routine
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Red Zone: Medical Alert

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 _____

Ambulance/Emergency Phone Number:

Continue control medicines and add:	How Much To Take	When To Take It
Medicine _____	_____	_____
_____	_____	_____
_____	_____	_____

<p>Go to the hospital or call for an ambulance if</p> <ul style="list-style-type: none"> <input type="radio"/> Still in the red zone after 15 minutes <input type="radio"/> if you have not been able to reach your physician/healthcare provider for help <input type="radio"/> _____ 	<p>Call an ambulance immediately if the following danger signs are present</p> <ul style="list-style-type: none"> <input type="radio"/> Trouble walking/talking due to shortness of breath <input type="radio"/> Lips or fingernails are blue
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