School City of Hammond

# Asthma Action Plan

Name: _____ DOB: _____ School: _____ Grade: _____

Parent Name(s): _____ PH: _____ Cell: _____ WK:_____

Other Contacts: _____ PH: _____ Cell: _____ WK:_____

Health Care Provider's Name: _____ PH: _____ Fax: _____

**THE AREAS BELOW ARE TO BE COMPLETED BY PHYSICIAN**

**Asthma is:**

☐ Intermittent or Persistent:

☐ Mild ☐ Moderate ☐ Severe

**Asthma is:**

☐ Well-Controlled ☐ Needs better control

**What Triggers my Asthma(Things that make it worse):**

☐ Colds ☐ Pollen ☐ Dust ☐ Smoke (tobacco, incense)

☐ Stress & emotions ☐ Exercise ☐ Gastric Reflux

☐ Mold/Moisture ☐ Animals:_____

☐ Strong Odors ☐ Other:_____

**HOLDING CHAMBER/SPACER**-to be used when taking inhaled medication: ☐ Yes ☐ No

**SELF CARRY/ADMINISTER**-in my opinion this child has the knowledge/skills to carry & self administer the medicines below: ☐ Yes ☐ No

## GREEN ZONE: GO!-Take these control medicines every day.

**You have all of these:**

- Breathing is good
- No cough or wheeze
- Can work/play easily
- Sleeping all Night

**Peak Flow is in this area:**
**_____ or greater**

Step 1: ☐ No control medicines required.

☐ Take these control medicine(s) every day:

_____ _____ _____
Inhaled medicine | Puffs | Frequency

_____ _____ _____
Medicine for Nebulizer Treatment | Dose | Frequency

Step 2: ☐ If exercise triggers Asthma, take the following medicine 15 minutes before exercise or sports. _____ _____
Inhaled Medicine | Puffs

## YELLOW ZONE: CAUTION-Continue control meds & Add Quick Relief Medicine.

**You have ANY of these:**

- First sign of a cold
- Cough or mild wheeze
- Tight Chest
- Problems sleeping, working and or playing

**Peak Flow is in this area:**
**_____ to _____**

Step 1: ☐ Keep taking GREEN ZONE control meds and ADD quick relief medicine.

_____ _____ _____ _____
Inhaled Medicine | Dose(puffs) | Repeat (hrs) | Max. Treatments dose

**OR** ☐ Nebulizer Treatment(s)

_____ _____ _____ _____
Medicine: | Dose: | Repeat (hrs) | Max.Treatments

☐ Other:_____

Step 2: **If symptoms are getting worse, follow the RED ZONE instructions!**

## RED ZONE: EMERGENCY-Get Help Now!

**You have ANY of these:**

- Hard to breathe
- Breathing hard and fast
- Trouble walking or talking
- Blue lips or fingernails
- Ribs show or nostrils open wide

**Peak Flow is in this area:**
**_____ or less.**

Step 1: ☐ Continue to take YELLOW ZONE medicine to maximum treatments.

☐ Add this medicine:

_____ _____ _____ _____
Inhaled Medicine | Dose (puffs) | Repeat (hrs) | Max. Treatments

Step 2: ☐ Call 911 ☐ Contact the parent's

This Asthma Action Plan gives authorization for the above medication (s) to be administered at school.

Physician Signature:_____ Date:_____

Parent/ Guardian Signature: _____ Date: _____