Asthma Action Plan

Effective Dates:

Name		Date of Birth
Health Care Provider	Emergency Contact	Emergency Contact
Provider Phone #	Phone: area code + number	Phone: area code + number
Fax #	Contact by text? ☐ YES ☐ NO	Contact by text? ☐ YES ☐ NO

Medical provider complete from here down

Asthma Triggers (Things that make your asthma worse)

☐ Colds
☐ Smoke (tobacco, incense)
☐ Pollen
☐ Dust
☐ Acid reflux
☐ Exercise
☐ Animals: ______________________
☐ Pests (rodents, cockroaches)
☐ Other: ______________________
☐ Strong odors
☐ Mold/moisture
☐ Stress/Emotions

Season
☐ Fall ☐ Spring
☐ Winter ☐ Summer

Asthma Severity: ☐ Intermittent Persistent: ☐ Mild ☐ Moderate ☐ Severe

Green Zone: Go! — Take these CONTROL Medicines every day at home

You have **ALL** of these:

- Breathing is easy
- No cough or wheeze
- Can work and play
- Can sleep all night

Peak flow: ______ to ______
(More than 80% of Personal Best)
Personal best peak flow:

Always rinse your mouth after using your inhaler. Remember to use a spacer with your MDI when possible. ☐ No control medicines

☐ Advair ______, ☐ Alvesco______, ☐ Arnuity _____, ☐ Asmanex _____

☐ Breo ______, ☐ Budesonide _____, ☐ Dulera ______, ☐ Flovent _____, ☐ Pulmicort _____

☐ QVAR Redihaler _____, ☐ Symbicort ______, ☐ Other: ____________

MDI: _____ puff (s) _____ times per day or **Nebulizer Treatment:** _____ times per day

Singulair/Montelukast take ________mg by mouth once daily

For Asthma with exercise/sports add: MDI w/spacer 2 puffs, 15 minutes prior to exercise:
☐ Albuterol ☐ Xopenex ☐ Ipratopium *If asymptomatic not more than every 6 hours*

Yellow Zone: Caution! — Continue CONTROL Medicines and ADD RESCUE Medicines

You have **ANY** of these:

- Cough or mild wheeze
- First sign of cold
- Tight chest
- Problems sleeping, working, or playing

Peak flow: ______ to ______
(60% - 80% of Personal Best)

☐ Albuterol ☐ Levalbuterol (Xopenex) ☐ Ipratropium (Atrovent)

MDI: _________ puffs with spacer every ______ hours as needed

☐ Albuterol 2.5 mg/3m1 ☐ Levalbuterol (Xopenex) ☐ Ipratropium (Atrovent) 2.5mg/3m1

Nebulizer Treatment: one treatment every ______ Hours as needed

Call your Healthcare Provider if you need rescue medicine for more than 24 hours or two times a week or if your rescue medicine does not work.

Red Zone: DANGER! — Continue CONTROL & RESCUE Medicines and GET HELP!

You have **ANY** of these:

- Can't talk, eat, or walk well
- Medicine is not helping
- Breathing hard and fast
- Blue lips and fingernails
- Tired or lethargic
- Ribs show

Peak flow: < __________
(Less than 60% of Personal Best)

☐ Albuterol ☐ Levalbuterol (Xopenex) ☐ Ipratropium (Atrovent)

MDI: ______ puffs with spacer **every 15 minutes,** for **THREE treatments**

☐ Albuterol 2.5 mg/3m1 ☐ Levalbuterol (Xopenex) ☐ Ipratropium (Atrovent)

Nebulizer Treatment: one nebulizer treatment **every 15 minutes,** for **THREE** treatments

Call 911 or go directly to the Emergency Department NOW!

I give permission for school personnel to follow this plan, administer medication and care for my child, and contact my provider if necessary. I assume full responsibility for providing the school with prescribed medication and delivery/ monitoring devices. I approve this Asthma Management Plan for my child.

PARENT/Guardian ___________________________________ Date_____________

INHALER AUTHORIZATION

Release and indemnification agreement

PART 1 TO BE COMPLETED BY PARENT		
I hereby request designated school personnel to administer an inhaler as directed by this authorization. I agree to release, indemnify, and hold harmless the designated school personnel, or agents from lawsuits, claim expense, demand or action, etc., against them for helping this student use an inhaler, provided the designated school personnel comply with the Licensed Healthcare Provider (LHCP) or parent or guardian orders set forth in accordance with the provision of part II below.		
Inhaler: □ Renewal □ New (If new, the first full dose must be given at home to assure that the student does not have a negative reaction) First dose was given: Date_____________ Time_____________		
Student Name (Last, First, Middle):	Date of Birth:	
Allergies:	School:	School Year:
_______________ Parent or Guardian Signature	_______________ Daytime Telephone	_______________ Date

PART II TO BE COMPLETED BY LICENSED HEALTH CARE PROVIDER (LAY LANGUAGE, NO ABBREVIATIONS)	
DIAGNOSIS:	LIST TRIGGERS:
SIGNS / SYMPTOMS:	MEDICATION AND ROUTE:
DOSAGE TO BE GIVEN AT SCHOOL:	INTERVAL FOR REPEATING DOSAGE:
TIME TO BE GIVEN:	COMMON SIDE EFFECTS:
EFFECTIVE DATE: Start: End:	If the student is taking more than one medication at school, list sequence in which inhalers are to be taken
Asthma action plan is attached.	

_______________ Licensed Health Care Provider (Print) _______________ Licensed Health Care Provider (Signature) _______________ Telephone _______________ Date