Asthma Action Plan for School Children Year 20__ - 20__

Name_____DOB_____Height_____

Personal Best Peak Flow_____ Severity: o Mild o Moderate o Severe o Exercise-Induced

Parent/Guardian_____ (H)_____ (C) _____

MD/DO/NP/PA_____ Ph _____

GREEN ZONE

GO

Green Zone _____
(>80% of best peak flow)

No rescue medication necessary

TAKE CONTROLLER MEDICINE EVERY DAY

DAILY MEDICINE	HOW MUCH	HOW OFTEN/WHEN

o EXERCISE-INDUCED ASTHMA: Rescue Inhaler:_____ use _____ puffs prior to hard exercise/sports. Can be repeated in 4 hours. **If symptoms occur with exercise, follow yellow zone.**

YELLOW ZONE

CAUTION

Yellow Zone _____To_____
(50-80% of best peak flow)

- **COUGH**
- **WHEEZE**
- **TIGHT CHEST**

If still having trouble, follow red zone.

RESCUE MEDICIINE

MEDICINE	HOW MUCH	HOW OFTEN/WHEN
Rescue medicine: _____	Take _____ puffs of metered dose inhaler o Spacer ____ nebulizer treatment (s)	Recheck peak flow in 15 min. If peak flow still in yellow zone, may repeat dose once. If still in yellow zone after 2nd dose, **call parent or doctor.** STAY WITH CHILD. GIVE DRINK OF CLEAR FLUIDS.

NOTE: Parent should contact the doctor if child needs rescue med >2 times in a week to see if a medication change is necessary.

RED ZONE

DANGER

RED ZONE lower than _____
(<50% of best peak flow)

- **MEDICINE IS NOT HELPING**
- **CONSTANT COUGH**
- **WORKING HARD TO BREATHE**

CHILD IS VERY SICK DANGER - GET HELP!

IF IN SEVERE DISTRESS, CALL 911

RESCUE MEDICINE	HOW MUCH	HOW OFTEN/WHEN
Rescue medicine: _____	Take _____ puffs of metered dose inhaler o Spacer ____ nebulizer treatment (s)	Recheck peak flow in 15 min. If peak flow still in red zone, may repeat dose once. If still in red zone after 2nd dose, **call parent or doctor.** STAY WITH CHILD. GIVE DRINK OF CLEAR FLUIDS.

_____ Initial I have instructed the student in the proper use of his/her rescue medicine and the student is able to perform procedure alone and may carry inhaler.

I hereby release the local School Board and their agents and employees from any liability that may result from my child taking the prescribed medication. I give permission for this student to receive medications and for health care providers to exchange information regarding the care of my child. I agree to provide rescue medication to be kept at school in case of emergency.

MD/DO/NP/PA:_____

Date_____ (update yearly)

Parent/Guardian:_____Date_____

WHITE - SCHOOL YELLOW - PATIENT/PARENT \\DAYTONA\Documents\HealthEd\AsthmaActionPlan\2017 **Albemarle Pediatric Asthma Coalition**