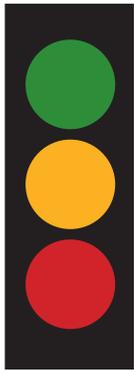


Asthma Action Plan for School Children Year 20__ - 20__



Name _____ DOB _____ Height _____

Personal Best Peak Flow _____ Severity: Mild Moderate Severe Exercise-Induced

Parent/Guardian _____ (H) _____ (C) _____

MD/DO/NP/PA _____ Ph _____

GO

TAKE CONTROLLER MEDICINE EVERY DAY

GREEN ZONE

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

No rescue medication necessary

DAILY MEDICINE	HOW MUCH	HOW OFTEN/WHEN

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.**

CAUTION

RESCUE MEDICINE

YELLOW ZONE

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

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

If still having trouble, follow red zone.

MEDICINE	HOW MUCH	HOW OFTEN/WHEN
Rescue medicine: _____	Take _____ puffs of metered dose inhaler <input type="radio"/> 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.

DANGER

IF IN SEVERE DISTRESS, CALL 911

RED ZONE

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!**

RESCUE MEDICINE	HOW MUCH	HOW OFTEN/WHEN
Rescue medicine: _____	Take _____ puffs of metered dose inhaler <input type="radio"/> 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 _____