American Academy of Allergy Asthma & Immunology

Asthma Action Plan for Home & School

Name: **Birthdate:**

Asthma Severity: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent
☐ He/she has had many or severe asthma attacks/exacerbations

Green Zone
Have the child take these medicines every day, even when the child feels well.

Always use a spacer with inhalers as directed.

Controller Medicine(s): _____

_____

Controller Medicine(s) Given in School: _____

Rescue Medicine: Albuterol/Levalbuterol _____ puffs every four hours as needed

Exercise Medicine: Albuterol/Levalbuterol _____ puffs 15 minutes before activity as needed

Yellow Zone
Begin the sick treatment plan if the child has a cough, wheeze, shortness of breath, or tight chest. Have the child take all of these medicines when sick.

Rescue Medicine: Albuterol/Levalbuterol _____ puffs every 4 hours as needed

Controller Medicine(s):

☐ Continue Green Zone medicines: _____

☐ Add: _____

_____

☐ Change: _____

If the child is in the **yellow** zone more than **24** hours or is getting worse, follow **red** zone and call the doctor right away!

Red Zone
If breathing is hard and fast, ribs sticking out, trouble walking, talking, or sleeping.
Get Help Now

Take rescue medicine(s) now
Rescue Medicine: Albuterol/Levalbuterol _____ puffs every _____

Take: _____

_____

If the child is not better right away, call 911
Please call the doctor any time the child is in the red zone.

Asthma Triggers: (List)

School Staff: Follow the Yellow and Red Zone plans for rescue medicines according to asthma symptoms.
Unless otherwise noted, the only controllers to be administered in school are those listed as "given in school" in the green zone.

☐ Both the asthma provider and the parent feel that the child may carry and self-administer their inhalers
☐ School nurse agrees with student self-administering the inhalers

Asthma Provider Printed Name and Contact Information:	Asthma Provider Signature: Date:

Parent/Guardian: I give written authorization for the medications listed in the action plan to be administered in school by the nurse or other school members as appropriate. I consent to communication between the prescribing health care provider/clinic, the school nurse, the school medical advisor and school-based health clinic providers necessary for asthma management and administration of this medication.

Parent/guardian signature: Date:	School Nurse Reviewed: Date:

Quick Relief and Emergency Plan

Immediate action is required when the student exhibits any of the following signs of respiratory distress:

Severe cough	Chest tightness	Shortness of Breath
Turning blue	Rapid, labored breathing	Sucking in of the chest wall
Wheezing	Shallow, rapid breathing	Difficulty walking from breathing
Difficulty talking from breathing	Decreased or loss of consciousness	

Steps to Take During an Asthma Episode:

1. Give Emergency Asthma Medications as Listed Below:

Quick Relief Medications	Dose/Frequency	When to Administer

2. Contact Parents if _____

3. Call Doctor if _____

4. Call 911 to activate EMS if the student has any of the following:
   - Lips or fingernails are blue or gray
   - Student is too short of breath to walk, talk, or eat normally
   - No relief from medication within 15-20 minutes with any of the following signs:
     - Chest and neck pulling in with breathing
     - Child is hunching over
     - Child is struggling to breathe
     - Other _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE THE STUDENT TO MEDICAL FACILITY

Parent/Guardian Signature _____ Date _____

Doctor's Signature _____ Date _____

Parent Consent for Management of Asthma at School

I, the parent or guardian of the above named student, request that this school Asthma Action Plan be used to guide the care of my child. I agree to:

1. Provide necessary supplies, equipment and medications
2. Notify the school of any changes in the student's health status
3. Notify the school and complete new consent for changes in orders from the student's health care provider
4. Authorize the school nurse to communicate with the primary care provider/specialist asthma/allergy as needed
5. Allow school staff interacting directly with my child to be informed about his/her special needs while at school.

_____ _____ _____

(Parent Name) (Parent Signature) (Date)