Asthma Action Plan

Name: _____ DOB: _____
School:
☐ Harbor Springs ☐ River Springs ☐ Empire Springs ☐ Citrus Springs
Site/Program: _____ Teacher: _____
Emergency Contact: _____ Phone: _____
Physician: _____ Phone: _____
Physician Signature: _____ Date: _____
Parent/Guardian Signature: _____ Date: _____
Reviewed by School Nurse: _____ Date: _____

☐ Student may carry asthma medication ☐ Student may self- administer medication

Severity Classifications	Triggers	Exercise
☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent	☐ Colds/Flu ☐ Dust ☐ Animals ☐ Exercise ☐ Pollen/Outdoor Mold ☐ Animals ☐ Odors/Sprays ☐ Smoke ☐ Weather/Air Pollution ☐ Other _____	1. Premedication (before exercise or other known trigger). How much & how often _____ 2. Activity Restrictions if any _____

Green Zone: Doing Well	Peak Flow Meter Personal Best = _____
Symptoms ■ No cough or wheeze ■ Can work/play (usual activities) ■ Breathing is good **Peak Flow is** _____ **or more**. (80% or more of personal best)	**Control Meds For School** **Medicine** **How much to take** **How often** _____ _____ _____ _____ _____ _____ **PREVENT** asthma symptoms every day: ●take controller medicines (above) every day ●avoid things that make asthma worse (triggers) ●before Exercise take _____ puffs of _____

Yellow Zone: Getting Worse	
Symptoms ■ Some problems breathing ■ Cough, wheeze, or chest tight ■ Problems working or playing ■ Wake at night **Peak Flow is** _____ **to** _____ (50-79%) of personal best	**Take Quick Relief Medications:** **Medicine:** **How much to take:** **How often:**

Red Zone: Medical Alert	Take Quick Relief Medication and Call 911:
Symptoms ■ Lots of problems breathing ■ Cannot work or play ■ Getting worse instead of better ■ Medicine is not helping **Peak Flow is** less than _____ (50% of personal best)	☐Trouble walking or talking due to shortness of breath ☐Fingernail or lips turn blue ☐ _____ ☐ _____

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