# Asthma Action Plan

AMERICAN LUNG ASSOCIATION®

**General Information:**

■ Name _____

■ Emergency contact _____ Phone numbers _____

■ Physician/healthcare provider _____ Phone numbers _____

■ Physician signature _____ Date _____

**Severity Classification**

❍ Intermittent ❍ Moderate Persistent
❍ Mild Persistent ❍ Severe Persistent

**Triggers**

❍ Colds ❍ Smoke ❍ Weather
❍ Exercise ❍ Dust ❍ Air Pollution
❍ Animals ❍ Food
❍ Other _____

**Exercise**

1. Premedication (how much and when) _____
_____
2. Exercise modifications _____
_____

## Green Zone: Doing Well

**Peak Flow Meter Personal Best =**

**Symptoms**

- ■ Breathing is good
- ■ No cough or wheeze
- ■ Can work and play
- ■ Sleeps well at night

**Control Medications:**

| Medicine | How Much to Take | When to Take It |
|---|---|---|
| | | |
| | | |
| | | |

**Peak Flow Meter**

More than 80% of personal best or _____

## Yellow Zone: Getting Worse

**Contact physician if using quick relief more than 2 times per week.**

**Symptoms**

- ■ Some problems breathing
- ■ Cough, wheeze, or chest tight
- ■ Problems working or playing
- ■ Wake at night

**Continue control medicines and add:**

| Medicine | How Much to Take | When to Take It |
|---|---|---|
| | | |
| | | |
| | | |

**Peak Flow Meter**

Between 50% and 80% of personal best or
_____ to _____

**IF your symptoms (and peak flow, if used) return to Green Zone after one hour of the quick-relief treatment, THEN**

- ❍ Take quick-relief medication every 4 hours for 1 to 2 days.
- ❍ Change your long-term control medicine by _____
- ❍ Contact your physician for follow-up care.

**IF your symptoms (and peak flow, if used) DO NOT return to Green Zone after one hour of the quick-relief treatment, THEN**

- ❍ Take quick-relief treatment again.
- ❍ Change your long-term control medicine by _____
- ❍ Call your physician/Healthcare provider within ____ hour(s) of modifying your medication routine.

## Red Zone: Medical Alert

**Ambulance/Emergency Phone Number:**

**Symptoms**

- ■ Lots of problems breathing
- ■ Cannot work or play
- ■ Getting worse instead of better
- ■ Medicine is not helping

**Continue control medicines and add:**

| Medicine | How Much to Take | When to Take It |
|---|---|---|
| | | |
| | | |
| | | |

**Peak Flow Meter**

Less than 50% of personal best or
_____ to _____

**Go to the hospital or call for an ambulance if:**

- ❍ Still in the red zone after 15 minutes.
- ❍ You have not been able to reach your physician/healthcare provider for help.
- ❍ _____

**Call an ambulance immediately if the following danger signs are present:**

- ❍ Trouble walking/talking due to shortness of breath.
- ❍ Lips or fingernails are blue.

# AUTHORIZATION AND PERMISSION FOR ADMINISTRATION OF MEDICATION

*(To Be Completed Annually by Physician)*

Student Name: _____ Date of Birth: _____

School Year: _____ Grade and Teacher: _____

This child is under my medical care for _____ (Diagnosis) and medication is required during the school day.

| Name of Drug | Dosage | Route | Frequency | Time To Be Given At School | Side Effects |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

☐ This student has been instructed in the self-administration of the above epinephrine auto-injector (ONLY), knows the circumstances under which to use the medication, and may carry the auto-injector. Prescriber's initials: _____

Signature of Physician: _____ Date: _____ OFFICE STAMP

Printed Name of Physician: _____ Physician's Office and Emergency Phone #: _____

**Asthma Inhalers - Parents please attach prescription label to the back of this form if student is self-administering.**

☐ My child has my permission to self-administer his/her asthma inhaler. Parent's initials: _____ By initialling here, the parent/guardian is responsible for the student carrying and maintaining their own inhaler.

**To Be Completed By Parent or Legal Guardian**

I give permission for my child to receive the above medication(s) as directed by the physician. I will bring the medication to the school nurse in a container labeled by the pharmacy. I will provide a written doctor's order if the medication dosage is changed or the medication is discontinued. For all medications other than self-administered asthma medications or epinephrine auto-injectors, I understand that it is the responsibility of the student to report to the RQA Front Office at the scheduled time to receive the medication. I further completely release and excuse RQA and its employees and agents of any liability or obligation of any nature in any way related to the school's medication policy and procedure.

“Self-administration” means that the student has the discretion as to the use of his/her asthma medication or epinephrine auto-injector (ONLY). Therefore, as the parent/guardian, I acknowledge that the student is responsible for having asthma medication or an epinephrine auto-injector available as needed, and that the student has demonstrated competency in the proper way to use the medication.

I, the parent/guardian of the above student acknowledge that, RQA Chicago Elementary School, along with its employees and agents, incur no liability as a result of any injury arising from the student's self-administration of asthma medication or epinephrine auto-injector. I indemnify and hold harmless the school, along with its agents and employees, against any claims (except a claim based upon willful and wanton conduct).

Parent signature and date: _____ Telephone: _____

Emergency contact name: _____ Telephone: _____