Asthma Action Plan

For: _____ Doctor: _____ Date: _____

Doctor's Phone Number _____ Hospital/Emergency Department Phone Number _____

GREEN ZONE

Doing Well

- No cough, wheeze, chest tightness, or shortness of breath during the day or night
- Can do usual activities

And, if a peak flow meter is used,

Peak flow: more than _____
(80 percent or more of my best peak flow)

My best peak flow is: _____

Take these long-term control medicines each day (include an anti-inflammatory).

Medicine	How much to take	When to take it
Before exercise	❒ _____	❒ 2 or ❒ 4 puffs _____	5 minutes before exercise

YELLOW ZONE

Asthma Is Getting Worse

- Cough, wheeze, chest tightness, or shortness of breath, or
- Waking at night due to asthma, or
- Can do some, but not all, usual activities

-Or-

Peak flow: _____ to _____
(50 to 79 percent of my best peak flow)

First

Add: quick-relief medicine—and keep taking your GREEN ZONE medicine.

_____ ❒ 2 or ❒ 4 puffs, every 20 minutes for up to 1 hour
(short-acting beta$_2$-agonist) ❒ Nebulizer, once

Second

If your symptoms (and peak flow, if used) return to GREEN ZONE after 1 hour of above treatment:
❒ Continue monitoring to be sure you stay in the green zone.

-Or-

If your symptoms (and peak flow, if used) do not return to GREEN ZONE after 1 hour of above treatment:
❒ Take: _____ ❒ 2 or ❒ 4 puffs or ❒ Nebulizer
(short-acting beta$_2$-agonist)
❒ Add: _____ mg per day For _____ (3–10) days
(oral steroid)
❒ Call the doctor ❒ before/ ❒ within _____ hours after taking the oral steroid.

RED ZONE

Medical Alert!

- Very short of breath, or
- Quick-relief medicines have not helped, or
- Cannot do usual activities, or
- Symptoms are same or get worse after 24 hours in Yellow Zone

-Or-

Peak flow: less than _____
(50 percent of my best peak flow)

Take this medicine:

❒ _____ ❒ 4 or ❒ 6 puffs or ❒ Nebulizer
(short-acting beta$_2$-agonist)

❒ _____ mg
(oral steroid)

Then call your doctor NOW. Go to the hospital or call an ambulance if:
- You are still in the red zone after 15 minutes AND
- You have not reached your doctor.

DANGER SIGNS
- **Trouble walking and talking due to shortness of breath**
- **Lips or fingernails are blue**
- **Take ❒ 4 or ❒ 6 puffs of your quick-relief medicine AND**
- **Go to the hospital or call for an ambulance _____ NOW!**
(phone)

See the reverse side for things can do to avoid your asthma triggers.

Signature Page for School Permission

This plan is in accordance with new legislation, HB1688, which passed during the 2001 Texas Legislative Session. This bill allows students to self-administer asthma medications while at school or school functions with permission from health care providers and parents.

(To be completed at the beginning of each school year and kept on file with the school nurse/campus designee)

Student Name: _____ Date of Birth: _____

Emergency Contact Name: _____ Phone: _____

Parent/Guardian: _____ Phone: _____ Alt Phone: _____
Health Care Provider student sees for asthma: _____ Phone: _____
(Optional) Other Health Care Provider: _____ Phone: _____

HEALTH CARE PROVIDER SECTION (To be completed by DO/MD/NP/PA)

_____Student instructed in proper use of their asthma medications, and in my opinion, CAN / CANNOT (*please circle*) carry a self-administered inhaler while on school property or at school-related events.

_____Student is to notify designated school health officials after using inhaler at school.

The attached Asthma Action Plan is the prescribed order of treatment for this student's asthma.

DO/MD/NP/PA Signature _____ Date _____

PARENT/GUARDIAN AGREEMENT

I agree with the recommendations of my child's health care provider as noted above and have informed my child that he/she may carry his/her asthma medications while on school property or at school-related events. I give permission for school personnel to follow this plan, administer medication and care for my child and contact my child's health care provider as necessary for asthma management and medication administration. I give permission to my child's school to administer daily and emergency medications as necessary, in accordance with health care provider's instructions above and on my child's Asthma Action Plan. I assume full responsibility for providing the school with prescribed medication and delivery/ monitoring devices. I approve this Asthma Management Plan for my child.

Parent/Guardian Signature _____ Date _____

CAMPUS/SCHOOL DISTRICT SECTION

Received by:

School Nurse/Designee Signature _____ Date _____

Copy of this Asthma Action Plan should be* provided to:

- ☐ Principal
- ☐ Cafeteria Manager
- ☐ Bus Driver/Transportation
- ☐ PE Teacher
- ☐ Coach
- ☐ School Administrative Staff
- ☐ Other School Staff