ASTHMA ACTION PLAN

Student Name ____________________ School ____________________ Grade ____________

Your child should have regularly scheduled asthma check ups and should be seen after any emergency room or hospital visit by their primary care provider. The child’s provider is:

name ____________________ phone #_____________________________

Other important instructions:
1. No smoking in your home or car, even if your child is not present
2. Always use a spacer with inhalers (MDIs) and rinse your child’s mouth out after using inhaled steroids
3. Take measures to remove or control known triggers in your child’s environment. Your child’s triggers are:
   - Respiratory infections or flu
   - Pollen
   - Dust, dust mites
   - Weather/temperature changes
   - Indoor pets
   - Exercise
   - Strong odors or sprays
   - Indoor/outdoor pollution
   - Household cleaners
   - Strong emotion
   - Cockroaches
   - Other allergies

4. It is the responsibility of the parent/guardian to provide medication.

GREEN ZONE – ALL CLEAR - GO

You are OK  □ No controller medicine needed at this time

You should have:  Medicine  Method  How Much  How often
- No wheezing
- No coughing
- No chest tightness
- No waking up at night because of Asthma
- No problems with play because of Asthma
- Peak flow number from _____ to _____ 15 minutes before exercise use _______ puffs (Inhaled)

YELLOW ZONE – CAUTION! – TAKE ACTION

Asthma getting worse  Continue to use green zone daily medicines and add:

You may have:  Medicine  Method  How much  How often
- Coughing
- Wheezing
- Chest Tightness
- First signs of a cold
- Coughing at night
- Peak flow number from _____ to _____

RED ZONE – STOP! – GET HELP NOW!

This is an emergency!

You may have:
- Quick relief medicine that is not helping
- Wheezing that is worse
- Faster breathing
- Blue lips or nail beds
- Trouble walking or talking
- Chest and neck pulled in with each breath
- Peak flow less than ________.

Continue to use green zone medicines and do the following:
- Use _____ puffs or 1 vial Albuterol/Xopenex inhaled every 20 minutes for a total of _____ doses.
- Call the doctor now at _______ for further instructions. If you cannot contact the doctor, go directly to the Emergency Room or call 911. DO NOT WAIT!!

Physician signature ____________________ Date ____________

Signature of Parent/Responsible Party ____________________ Date: ____________

School Health Nurse Signature ______________________________ Date: ____________

I, the parent of ____________________________, authorize the release and exchange of medical information between any of my child’s health care providers and Hendricks Regional Health. I understand that this is for continuity of care purposes and may occur as needed without any prior notification or additional authorization throughout my child’s care in the school system.

Parent/Guardian Signature ______________________________ Date: ____________