Asthma Action Plan for Home and School

AMERICAN LUNG ASSOCIATION.

Name _____ DOB ____/____/_____

Severity Classification ☐Intermittent ☐Mild Persistent ☐Moderate Persistent ☐Severe Persistent

Asthma Triggers (list) _____

Peak Flow Meter Personal Best ____

Green Zone: Doing Well

Symptoms: Breathing is good – No cough or wheeze – Can work and play – Sleeps well at night
Peak Flow Meter _____ (more than 80% of personal best)

Control Medicine(s)	Medicine	How much to take	When and how often to take it	Take at
	_____	_____	_____	☐Home ☐School
	_____	_____	_____	☐Home ☐School

Physical Activity ☐Use albuterol/levalbuterol ____ puffs, 15 minutes before activity ☐with all activity ☐when the child feels he/she needs it

Yellow Zone: Caution

Symptoms: Some problems breathing – Cough, wheeze, or chest tight – Problems working or playing – Wake at night
Peak Flow Meter _____ to _____ (between 50% and 79% of personal best)

Quick-relief Medicine(s) ☐Albuterol/levalbuterol ____ puffs, every 4 hours as needed

Control Medicine(s) ☐Continue Green Zone medicines

☐Add _____ ☐Change to _____

The child should feel better within 20–60 minutes of the quick-relief treatment. If the child is getting worse or is in the Yellow Zone for more than 24 hours, THEN follow the instructions in the RED ZONE and call the doctor right away!

Red Zone: Get Help Now!

Symptoms: Lots of problems breathing – Cannot work or play – Getting worse instead of better – Medicine is not helping
Peak Flow Meter _____ (less than 50% of personal best)

Take Quick-relief Medicine NOW! ☐Albuterol/levalbuterol ____ puffs, _____ (how frequently)

Call 911 immediately if the following danger signs are present
- Trouble walking/talking due to shortness of breath
- Lips or fingernails are blue
- Still in the red zone after 15 minutes

School Staff: Follow the Yellow and Red Zone instructions for the quick-relief medicines according to asthma symptoms.
The only control medicines to be administered in the school are those listed in the Green Zone with a check mark next to "Take at School".

☐**Both the Healthcare Provider and the Parent/Guardian** feel that the child has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

Healthcare Provider

Name _____ Date _____ Phone (_____) _____-_____ Signature _____

Parent/Guardian

☐I give permission for the medicines listed in the action plan to be administered in school by the nurse or other school staff as appropriate.
☐I consent to communication between the prescribing health care provider or clinic, the school nurse, the school medical advisor and school-based health clinic providers necessary for asthma management and administration of this medicine.

Name _____ Date _____ Phone (_____) _____-_____ Signature _____

School Nurse

☐The student has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

Name _____ Date _____ Phone (_____) _____-_____ Signature _____

Please send a signed copy back to the provider listed above.

Ohio Department of Health
Authorization for Student Possession and Use of an Asthma Inhaler
In accordance with ORC 3313.716/3313.14

A completed form must be provided to the school principal and/or nurse before the student may possess and use an asthma inhaler in school to alleviate symptoms, or before exercise to prevent the onset of asthmatic symptoms.

Student's name
Student address

This section must be completed and signed by the student's parent or guardian.

As the Parent/Guardian of this student, I authorize my child to possess and use an asthma inhaler, as prescribed, at the school and any activity, event, or program sponsored by on in which the student's school is a participant.

Parent/Guardian Signature	Date
Parent/Guardian Name	Parent/Guardian emergency telephone number ( )

This section must be completed and signed by the student's physician.

Name and dosage of medication	
Date medication administration begins	Date medication administration ends (if known)
Procedures for school employees if the medication does not produce the expected relief	

Possible severe adverse reactions:

To the student for whom it is prescribed (that should be reported to the physician)
To a student whom it is ***not*** prescribed who receives a dose
Special Instructions

Physician signature	Date
Physician Name	Physician emergency telephone number ( )

Adapted from the Ohio Association of School Nurses