ALVIN INDEPENDENT SCHOOL DISTRICT

Asthma Action Plan

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

Student Name: _____ **DOB**: _____ **Grade**: _____

Homeroom Teacher: _____ **Parent/Guardian Name**: _____

Home Phone: _____ **Work/Cell Phone**: _____

Emergency Contact Information (in case parent cannot be reached)

_____

Name Relationship to Student Phone

Physician treating student's asthma: _____ **Phone**: _____

Health Care Provider: Please complete all items in box:

Asthma Severity: ☐ Intermittent ☐ Mild persistent ☐ Moderate persistent ☐ Severe persistent

Controller Medication(s) given at home: _____

Asthma Episode Triggers (check all that apply to student):

☐ Exercise ☐ Strong odors/fumes ☐ Carpet ☐ Mold ☐ Pollens ☐ Animals _____
☐ Respiratory infections ☐ Change in temperature ☐ Dust ☐ Foods _____
☐ Other _____

Asthma Management

"Green Zone" (Safety Zone)

- Breathing is easy
- No cough or wheeze
- Can do usual activities
- No asthma symptoms at night
- Peak flow from _____to_____

Use these controller medications as listed:

Medication	Dose	When/How Often

"Yellow Zone" (Caution Zone)

- Some shortness of breath
- Cough, wheeze, or chest tightness
- Some difficulty doing usual activities
- Sleep disturbed by symptoms
- Cold/flu symptoms
- Peak flow from _____to_____

Continue with controller medications as above, and add these rescue medications.

Medication	Dose	When/How Often

"Red Zone" (Danger Zone)

- Severe difficulty breathing
- Cannot do usual activities
- Difficulty walking and talking
- Rescue medications are not helping
- Peak flow from _____to_____

IF SYMPTOMS DON'T IMPROVE, CALL 911 IMMEDIATELY!

Take this medicine and call parent and doctor immediately!

Medication	Dose	When/How Often

Other Instructions: _____

Provider Signature: _____ **Date:** _____

Provider Printed Name: _____ **Phone:** _____

Parent/Guardian Signature: _____ **Date:** _____

School Nurse Signature: _____ **Date:** _____