ASTHMA ACTION PLAN

WALL ISD
HEALTH SERVICES

NAME:_____DOB:_____GRADE/TEACHER:_____

SEVERITY CLASSIFICATION:_____ ASTHMA TIGGERS (list):_____

PARENT/GUARDIAN:_____ PHONE:_____

EMERGENCY CONTACT:_____ PHONE:_____

PHYSICIAN STUDENT SEES FOR ASTHMA:_____ PHONE:_____

GREEN ZONE: PREVENTATIVE

Symptoms: Breathing is good- No cough or wheeze- Can work and play- Sleeps well at night. Use controller medicines daily at home.

Control Medicine(s): Takes at…

_____ ☐ Home ☐ School

_____ ☐ Home ☐ School

Physical Activity: Pre-treatment before PE/recess (as needed):

☐ Give Albuterol/Levalbuterol _____ puffs, 15 minutes before PE/recess ☐ with all activity ☐ as needed with activity

YELLOW ZONE: CAUTION

Symptoms: Some problems breathing- cough, wheeze, or chest tight- problems working or playing- coughing/wakes at night

Continue controller medicines at home daily.

Give:

☐ Albuterol/Levalbuterol _____ puffs four times daily or every _____ hours as needed.

☐ Albuterol/Levalbuterol by nebulizer 1 unit dose vial every 4 hours as needed.

☐ Other: _____

If no improvement, call the parent or emergency contact listed above.

RED ZONE: EMERGENCY PLAN

Symptoms: Very short of breath- cough or wheeze is constant-cannot work or play- reliever medications are not helping

Give:

☐ Albuterol/Levalbuterol _____puffs, _____ (how frequently)

☐ Give rescue medication and repeat _____ times _____ minutes apart.

Notify parent/emergency contact and have them pick up student.

Call 911 immediately for the following: Trouble walking/talking due to shortness of breath, lips or fingernails are blue, or student is still in the red zone after 15 minutes.

Attention Physician **(Please check one)**	☐ It is my professional opinion that the child has demonstrated the skills to carry and self-administer the above medications while on school property or at school-related events. ☐ It is my professional opinion that the child should NOT be allowed to carry and self-administer any of their asthma medications while on school property or at school related events.

Physician Signature:_____**Date:**_____

I agree with the recommendation of my child's physician as noted above:

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

****MUST BE SIGNED BY BOTH PARENT AND PHYSICIAN TO BE VALID**

School Year:_____