GREAT HEARTS ACADEMY – ASTHMA ACTION PLAN for the 2022/2023 SCHOOL YEAR

CHILD **LAST** NAME: ____
FIRST NAME:__________________________DOB: ________________
PARENT/GUARDIAN: _______________________________________
BEST CONTACT PHONE NUMBER: ____________________________
PHYSICIAN NAME: ____
PHYSICIAN PHONE NUMBER: _______________________________
TEACHER:________________________________ROOM # ___________

☐ ASTHMA TRIGGERS: EXERCISE STRONG ODORS OR FUMES RESPIRATORY INFECTIONS
ANIMALS DUST TEMPERATURE CHANGES POLLENS
MOLDS FOOD CARPET OTHER: ____________________________

Does your student use a peak flow monitor?________yes________no
Personal best peak flow number:______________________________Monitoring times during the day: ________________________

☐ DAILY PREVENTION/MANAGEMENT PLAN: *(Breathing is good, no cough or wheeze, can sleep through the night, can work and play OR other specific symptoms such as____)*

CONTROLLER MEDICATION	DOSE	FREQUENCY	Given to school nurse?

☐ BEGINNING SYMPTOMS: *(First signs of a cold, exposure to known trigger, cough, wheeze, chest tightness, coughing at night OR other specific symptoms such as____)*

RESCUE MEDICATION	DOSE	FREQUENCY	Given to school nurse?

1. Use the rescue medications listed above or ____
2. Have student return to class if ____
3. Contact parent if ____

☐ WORSENING SYMPTOMS: (*Medicine is not helping, breathing is hard and fast, nose opens wide, can't talk well, getting nervous OR other specific symptoms such as____)*

EMERGENCY MEDICATION	DOSE	FREQUENCY	Given to school nurse?

Call 9-1-1 if the student

1. Shows no improvement in 15-20 minutes after the rescue and emergency treatments are used, and the above-mentioned parent-guardian cannot be reached
2. Difficulty breathing, walking, or talking
3. Lips or fingernails are blue or gray or other ____

I understand that school staff MUST be informed of my child's health concerns in order to provide safe and appropriate care. I will update the school nurse office as my child's health conditions/treatments change throughout the year.

Parent/Guardian signature:____Date: ______________

My Asthma Action Plan

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
	__________	__________	__________
	__________	__________	__________

Physical Activity ☐ Use Albuterol/Levalbuterol _____ puffs, 15 minutes before activity

☐ with all activity ☐ when you feel you need it

Yellow Zone: Caution

Symptoms: Some problems breathing – Cough, wheeze, or tight chest – 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 ______________

You should feel better within 20–60 minutes of the quick-relief treatment. If you are getting worse or are 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

Emergency Contact Name ______________________________ Phone (______) ______ - ________

Emergency Contact Name ______________________________ Phone (______) ______ - ________

Date: ____ / ____ / ______