

GREAT HEARTS ACADEMY – ASTHMA ACTION PLAN 2023/2024 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: _____
 Physician 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: ____ / ____ / ____