Deer Creek Public School
ASTHMA ACTION PLAN

School: **Teacher:** **Grade:**

Student Name		**Date of Birth**
Parent/Guardian	**Parent Guardian Phone**	**Parent/Guardian Email**
Emergency Contact		**Emergency Contact Phone**

Asthma Triggers (Things that make your asthma worse)

☐ Colds	☐ Dust	☐ Animals:_____	☐ Strong odors	Season
☐ Smoke	☐ Acid reflux	☐ Pests (rodents, cockroaches)	☐ Mold/Moisture	☐ Fall ☐ Spring
☐ Pollen	☐ Exercise	☐ Other:_____	☐ Stress/Emotions	☐ Winter ☐ Summer

Asthma Severity: ☐ **Intermittent or** ☐ **Persistent:** ☐ **Mild** ☐ **Moderate** ☐ **Severe**

Green Zone: Go!

You have **ALL** of these:

- Breathing is easy
- No cough or wheeze
- Can work and play
- Can sleep at night

Take these CONTROL (PREVENTION) Medicines at Home Every Day

☐ No control medicines required

☐ Advair ☐ Flovent ☐ Pulmicort ☐ Symbicort ☐ Singulair (Montlukast)

☐ Other: _____

For asthma with exercise, ADD: ☐ Albuterol ☐ Other_____

MDI _____ puffs _____ minutes before exercise at school ☐ **PE class** ☐ **Recess** ☐ **Sports**

Yellow Zone: Caution!

You have **ANY** of these:

- Cough or mild wheeze
- First sign of cold
- Tight chest
- Problems sleeping, working, or playing

Continue CONTROL Medicines and ADD RESCUE Medicines

☐ Albuterol ☐ Levalbuterol (Xopenex) ☐ Ipratropium (Atrovent)

MDI _____ puffs every _____ hours as needed

☐ Albuterol 2.5mg/3ml ☐ Levalbuterol (Xopenex) _____ ☐ Ipratropium (Atrovent) 2.5 mg/3 ml

One nebulizer treatment every _____ hours as needed

☑ Other: _____

Call your Healthcare Provider if you need rescue medicine for more than 24 hours or two times a week, or if your rescue medicine doesn't work.

Red Zone: DANGER!

You have **ANY** of these:

- Can't talk, eat or walk well
- Medicine is not helping
- Breathing hard and fast
- Blue lips and fingernails
- Tired or lethargic
- Ribs show

Continue CONTROL & RESCUE Medicines and GET HELP!

☐ Albuterol ☐ Levalbuterol (Xopenex) ☐ Ipratropium (Atrovent)

MDI _____ puffs **every 15 minutes**, for **THREE** treatments

☐ Albuterol 2.5mg/3ml ☐ Levalbuterol (Xopenex) _____ ☐ Ipratropium (Atrovent) 2.5 mg/3 ml

One nebulizer treatment **every 15 minutes**, for **THREE** treatments

☐ Other: _____

CALL 911

I give permission for school personnel to follow this plan, administer medication and care for my child and contact my provider if necessary. I understand this Asthma Action Plan must match the Authorization for Medication form completed by my Healthcare Provider. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I understand this plan is valid for this school year only and must be renewed at the beginning of each school year.

Parent/Guardian _____Date_____

School Nurse_____Date_____

☐ Teachers ☐ Coach/PE ☐ Office Staff ☐ Bus Driver/Transportation

Revised 2/2018