



# Asthma Action Plan

Patient Name		
Birth Date		Today's Date:
Effective Dates	From:	To:
Doctor/Nurse	Telephone:	
Parent/Guardian	Telephone:	

## Check Asthma Severity

- Mild Intermittent
- Mild Persistent
- Moderate Persistent
- Severe Persistent

### Trigger List:

- Chalk dust
- Cigarette smoke
- Colds/flu
- Dust or dust mites
- Stuffed Animals
- Carpet
- Exercise
- Mold
- Ozone alert days
- Pests
- Pets
- Plants, flowers, cut grass, pollen
- Strong odors, perfume, cleaning products
- Sudden change in temperature
- Wood smoke
- Foods:
- Other:

## GO – You're Doing Well! → Use these daily controller medicines

<p><b>You have <u>all</u> of these:</b></p> <ul style="list-style-type: none"> <li>Breathing is good</li> <li>No cough or wheeze</li> <li>Sleep through the night</li> <li>Can go to school and play</li> </ul>	MEDICINE/ROUTE	HOW MUCH	HOW OFTEN/WHEN

## CAUTION – Slow Down! → Take Your Quick Relief Medicine

Reminder: Exercise Induced Asthmatics Take your Quick Relief Medicine 15 minutes prior to exercise.

<p><b>You have <u>any</u> of these:</b></p> <ul style="list-style-type: none"> <li>Cough</li> <li>Mild wheeze</li> <li>Tight chest</li> <li>Trouble breathing at night</li> <li>Shortness of breath</li> </ul>	MEDICINE/ROUTE	HOW MUCH	HOW OFTEN/WHEN

- Relax and take slow deep breaths.
- Rest in a comfortable position, but not lying down.
- If symptoms RESOLVE within 20 minutes, student may return to class.
- If symptoms PERSIST or return within a few hours, follow red zone directions & contact parent.

## DANGER – Get Help! → Take Rescue Medicines & call your doctor!

<p><b>Your asthma is getting worse fast:</b></p> <ul style="list-style-type: none"> <li>Medicine is not helping <input type="checkbox"/> Y <input type="checkbox"/> N</li> <li>Breathing is hard &amp; fast <input type="checkbox"/> Y <input type="checkbox"/> N</li> <li>Nose opens wide <input type="checkbox"/> Y <input type="checkbox"/> N</li> <li>Ribs show <input type="checkbox"/> Y <input type="checkbox"/> N</li> <li>Can't talk well or walk <input type="checkbox"/> Y <input type="checkbox"/> N</li> <li>Blueness of lips <input type="checkbox"/> Y <input type="checkbox"/> N</li> </ul>	MEDICINE/ROUTE	HOW MUCH	HOW OFTEN/WHEN

- Take Quick Relief Medicine
- Use nebulizer if available until ambulance arrives
- Immediate action is needed: Call an ambulance!

### This represents an order for medication listed above

Child has been instructed to self-administer above medication – can self-carry.

Doctor/NP/PA Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I give permission to the school nurse, my child's doctor/NP/PA or \_\_\_\_\_ to administer ordered medication and share pertinent information about my child's asthma.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_