ASTHMA ACTION PLAN

Place Child's Picture Here

Student Name_____

Date of Birth_____ School Year_____

Parent/Guardian _____ Phone _____ Cell_____

Other Emergency Contact _____ Phone _____ Cell _____

Student's Primary Doctor: _____ Phone _____

Student's Asthma Doctor: _____ Phone _____

Medication Orders

- ❑ Albuterol Inhaler 2 sprays
- ❑ Albuterol nebulizer solution 3cc premix vial (0.083%)
- ❑ Time to be given: _____
- ❑ Repeat dose every 20 minutes up to _____ times

Physician Signature	Date:
Physician Printed Name	Phone: _____ Fax: _____

Asthma Emergency Plan

Do this first when asthma symptoms occur❼	**I authorize and request the school nurse and trained school personnel to administer the above medication as prescribed. This is a test dose to see if the student's asthma improves with albuterol.** **I request and authorize the above medication to be administered during field trips during the current school year.**
What to Do Next:	**When to Do It:**
Have the student return to the classroom. Notify parents of need for quick relief.	**(Green Zone) Good Response to Test Dose of Albuterol** ● The student's symptoms improve after 1-2 treatments. ● The student no longer has symptoms (wheezing, coughing, shortness of breath, chest tightness).
Contact parent or guardian. Other _____	**(Yellow Zone) Moderate Response to Test Dose of Albuterol** ● The student is experiencing mild to moderate symptoms (wheezing, coughing, shortness of breath, chest tightness) after taking up to 3 treatments. ● The student cannot do normal school activities.
Seek emergency medical care (in most locations, call 911). Other_____ NOTE: There might not be wheezing, because air cannot move out of the airways.	**(Red Zone) Poor Response to Test Dose of Albuterol** ● The student does not feel any better 20-30 minutes after taking albuterol. ● The student has severe symptoms (coughing, extreme shortness of breath, skin between ribs and neck pulled tight). ● The student has trouble walking or talking. ● The student's lips or fingernails are blue. ● The student is struggling to breathe.
Parent Signature	Date

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ASTHMA QUESTIONNAIRE

Contact Information

Student Name_____ School Year _____Date of Birth _____

Grade_____ School _____Teacher/Team _____

Parent/Guardian _____Phone _____ Work _____ Cell _____

Parent/Guardian Email _____

Other Emergency Contact _____ Phone _____Work _____ Cell _____

Child's Asthma Provider _____ Phone _____ Location _____

Child's Primary Doctor _____ Phone _____ Location _____

Asthma Information

When was your child diagnosed with Asthma? _____

How many times has your child been taken to an ER due to Asthma? _____ Date of last visit _____

How many times has your child been placed in the hospital due to Asthma? _____ Date of last visit _____

How many days of school did your child miss due to asthma last year? _____

Severity Classification

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

Triggers (Check all that apply)

- ☐ Colds
- ☐ Smoke
- ☐ Weather
- ☐ Exercise
- ☐ Dust
- ☐ Air pollution
- ☐ Animals
- ☐ Food
- ☐ Emotions
- ☐ Other

Symptoms your child experiences before or during an asthma episode. (Check all that apply)

- ☐ Cough
- ☐ Tightness in chest
- ☐ Rubbing chin/neck
- ☐ Shortness of Breath
- ☐ Breathing hard/fast
- ☐ Feeling tired/weak
- ☐ Wheezing
- ☐ Runny Nose
- ☐ Other _____

Daily Medication Plan

What daily medications does your child take so that:	Medication/Dose	When to Give it
• The child has no asthma symptoms. • The child can do usual activities. • The child can sleep without symptoms.	❑ Albuterol inhaler 2 sprays, OR ❑ Albuterol nebulizer solution 1 treatment ❑ _____ ❑ _____ ❑ Albuterol inhaler 2 sprays OR nebulizer 1 treatment	Every 4-6 hours ***as needed*** for wheezing/cough _____ _____ 15-20 minutes before exercise, ***If needed***

Authorization to Release/Obtain Information

I authorize the release of information about the specialized health care procedures/services related to my child's condition between the child's prescribing physician, the school nurse, and school personnel who care for my child and may need to know this information to maintain my child's health and safety. This authorization will be in effect for the above stated school year.

Signature of Parent/Guardian _____ Date _____

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