Asthma Action Plan

AMERICAN LUNG ASSOCIATION.

General Information:

- Name _____
- Emergency contact _____ Phone numbers _____
- Physician/healthcare provider _____ Phone numbers _____
- Physician signature _____ Date _____

Severity Classification

○ Intermittent ○ Moderate Persistent
○ Mild Persistent ○ Severe Persistent

○ Colds ○ Smoke ○ Weather
○ Exercise ○ Dust ○ Air Pollution
○ Animals ○ Food
○ Other _____

1. Premedication (how much and when) _____
2. Exercise modifications _____

Green Zone: Doing Well

Peak Flow Meter Personal Best =

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 or _____

Control Medications:

Medicine	How Much to Take	When to Take It

Yellow Zone: Getting Worse

Contact physician if using quick relief more than 2 times per week.

Symptoms

- Some problems breathing
- Cough, wheeze, or chest tight
- Problems working or playing
- Wake at night

Peak Flow Meter

Between 50% and 80% of personal best or _____ to _____

Continue control medicines and add:

Medicine	How Much to Take	When to Take It

IF your symptoms (and peak flow, if used) return to Green Zone after one hour of the quick-relief treatment, THEN

○ Take quick-relief medication every 4 hours for 1 to 2 days.
○ Change your long-term control medicine by _____
○ Contact your physician for follow-up care.

IF your symptoms (and peak flow, if used) DO NOT return to Green Zone after one hour of the quick-relief treatment, THEN

○ Take quick-relief treatment again.
○ Change your long-term control medicine by _____
○ Call your physician/Healthcare provider within ____ hour(s) of modifying your medication routine.

Red Zone: Medical Alert

Ambulance/Emergency Phone Number:

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 or _____ to _____

Continue control medicines and add:

Medicine	How Much to Take	When to Take It

Go to the hospital or call for an ambulance if:

○ Still in the red zone after 15 minutes.
○ You have not been able to reach your physician/healthcare provider for help.
○ _____

Call an ambulance immediately if the following danger signs are present:

○ Trouble walking/talking due to shortness of breath.
○ Lips or fingernails are blue.

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FLORIDA DEPARTMENT OF HEALTH IN MIAMI-DADE COUNTY
SCHOOL HEALTH PROGRAM
ROLES AND RESPONSIBILITIES - ASTHMA

Student: _____ **DOB**_____ **Teacher:** _____ **Grade:** _____
School: _____ **Parent/Guardian & Phone(s):** _____
Physician & Phone: _____ **School Year:**_____
KNOWN ALLERGIES: _____

Follow the attached physician action plan; <u>if no plan submitted</u>, call 911 and parent/guardian.

School Responsibilities/Agreements	Family Responsibilities/Agreements	Student Responsibilities/Agreements
1. Medication Kept: _____ Staff authorized to administer medication (review plan, recognize symptoms and respond) :	1. Provide medication authorization and corrected labeled medication for school sites and, when necessary for field trips. Replace any expired medication	1. Report early warning signs of asthma episodes
2.Trained staff to administer medications:	2. Keep school staff informed of any changes in student condition or medications. New authorization form required for any changes of medication	2. If applicable, carry rescue medication as directed by physician
3. Staff to contact 911/parent/guardian:	3. If applicable, Parent to obtain practitioner order for self-carry medication and to ensure that student is carrying rescue medication as directed	
4. Staff to direct EMS to the emergency	4. Parent or designated adult, as noted on emergency alert card, to respond to school when called	
5. CPR certified staff:	Parental consent should be on file for sharing health information	
6. Need to know staff /Substitute teachers should have knowledge of plan of care of student.		

_____ _____
Parent/Guardian Signature Date

_____ _____
Principal or School Administration Designee Date

_____ _____
School Nurse Date

Revised November 2013

FLORIDA DEPARTMENT OF HEALTH IN MIAMI-DADE COUNTY
SCHOOL HEALTH PROGRAM
HEALTH HISTORY AND CONSENT
ASTHMA

Student: _____ **DOB**_____ **Teacher:** _____ **Grade:** _____
School: _____ **Parent/Guardian & Phone(s):** _____
Physician & Phone: _____ **School Year:** _____
KNOWN ALLERGIES: _____

Dear Parent/Guardian:
School records or medical information indicates your child has asthma. In order to attend to your child's health and safety, the school requires a health history. Please return this form to the nurse as soon as possible. It will become part of your child's confidential school health record. Our primary concern is that your child's healthcare needs are met while in school.

_____ _____ _____
School Nurse Phone number Date

1. When was your child diagnosed? _____When was your child last asthma episode? _____
2. Has your child ever been hospitalized for asthma? Yes__ No__, If yes, when_____
3. What triggers your child's asthma episodes? (☑ All boxes that apply)
   ☐ Pollen ☐ Mold ☐ Dust ☐ Feathers ☐ Animal Dander ☐ Perfume ☐ Air pollution ☐ Smoke
   ☐ Respiratory infections ☐ Cold air ☐ Weather changes ☐ Vigorous exercise ☐ Foods
   (specify) _____
   ☐ Other _____
4. What are your child's asthma symptoms? (☑all boxes that apply)
   ☐ Coughing ☐ Wheezing ☐ Chest tightness ☐ Anxiety/Restlessness ☐ Difficulty breathing/shortness of breath
   ☐ Other (specify) _____
5. Please list the medications your child takes for asthma:

Name of Medication	Dosage	Time

6. List any **other medications** your child takes:

Name of Medication	Dosage	Time

7. List any side effects your child experiences from his/her medication? _____
8. Does your child have any activity or dietary restrictions? Yes, No (Doctor's letter required if activity is limited) _____
9. Self-care: Does your child know:

How to identify asthma triggers (what causes asthma attack)	Yes	No
The warning signs of asthma attack?	Yes	No
What medication to take?	Yes	No
To tell an adult if not feeling well	Yes	No

Please circle your response and sign:**(I do /I do not)** give the School Nurse my permission to share information relevant to my child's medical status with school staff on a "need to know" basis, if she/he determines that this information is necessary to assure my child's health and safety.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

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School Health Program

Student Asthma Checklist

Student Name: _____

School Nurse: _____ **Date:** _____

The student has demonstrated understanding and competency consistently to:

SKILLS	YES	NO	COMMENTS
1. Identify asthma triggers			
2. Identify signs and symptoms of asthma episode or early distress			
3. State knowledge of medication: A. Correct name and expiration date B. Side effects C. Adverse reactions D. Appropriate use of medication per order E. Appropriate use of equipment/device(MDI, inhaler, flow meter and nebulizer)			
4. Understands the importance to alert staff of poor response to self-administered medication			
5. State the need to call 9-1-1			

The student agrees to follow the safety precautions with medication compliancy and report any signs distress.

Student Signature_____ Date: _____

Parent Name/Signature_____ Date_____

I hereby acknowledge that the student listed above has demonstrated all the above listed skills.

School Nurse Signature_____ Date_____

Review Dates: _____ _____ _____ _____ _____ _____ _____