**Red Oak I.S.D. Asthma Action Plan**

Student Name: DOB: Date:

Parent/Guardian: Cell: Other number:

Physician: Phone number:

Medication Allergies:

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| **TO BE COMPLETED BY PHYSICIAN** | | | | |
| Check all items that trigger or make your asthma worse:  □colds □smoke □pollen □dust □animals:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □strong odors □mold/moisture □pests □exercise  □stress/emotions □gastroesophageal reflux □Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □Season: fall winter spring summer (circle)  □Foods: (list)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | **Asthma Severity:**  □Intermittent or persistent  □mild □moderate □severe  **Asthma Control:**  □well-controlled  □needs better control |
| **GREEN ZONE: Go! Take these Prevention Medications every day** | | | | |
| Peak flow in this area:  \_\_\_\_\_\_to \_\_\_\_\_\_\_  (more than 80% of personal best)  Predicted or Personal best  Peak flow:\_\_\_\_\_\_\_\_\_\_\_\_  Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □No control medicines required  □List control medication:   |  |  |  | | --- | --- | --- | | Medication | Dose/Route | Frequency/Time | |  |  |  | |  |  |  | |  |  |  |   Exercise pretreatment:  □\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5-15 minutes before exercise  □If symptoms recur with exercise, may repeat \_\_\_ puff(s), or \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □Measure Peak Flow prior to recess/PE: restrict aerobic activity if peak flow is below\_\_\_\_% | | | |
| **YELLOW ZONE: CAUTION! Continue CONTROL medicines and ADD rescue medicines** | | | | |
| Peak flow in this area:  \_\_\_\_\_to \_\_\_\_\_  (50%-80% of personal best)   * First sign of a cold * Cough or mild wheeze * Tight chest * Activity intolerance | | □\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_puff(s) MDI every \_\_\_\_\_hours as needed  OR  □\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_via nebulizer every \_\_\_\_\_hours as needed  □OTHER  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **RED ZONE: EMERGENCY! Continue CONTROL & RESCUE medicine and GET HELP** | | | | |
| Peak flow in this area:  \_\_\_\_\_to \_\_\_\_\_  (less than 50% personal best)   * Can’t talk, eat or walk well * Medicine is not helping * Breathing hard and fast * Blue lips & fingernails * Tired or lethargic * Ribs show (retractions) | | □\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_puff(s) MDI. May repeat every \_\_\_\_\_minutes  OR  □\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_via nebulizer for \_\_\_\_\_(number) of treatments  □Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **CALL 911 IF STUDENT DOES NOT IMPROVE QUICKLY!** | | |
| **Student Self-Administration**  Texas law permits students to carry & use prescription asthma medications at school after demonstrating to the student’s healthcare provider and school nurse the skill level necessary to  self-administer (ED §38.015) | | | □This student has been instructed in the proper use of his/her asthma medications, and  in my opinion, the student can carry and use his/her inhaler at school.  □Student is to notify his/her designated school health officials after using inhaler at  school.  □Student needs supervision or assistance, and should **NOT** carry his/her inhaler at  school. | |
| Healthcare Provider Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Healthcare Provider Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_ | | | | |