Red Oak I.S.D. Asthma Action Plan

Student Name:_____ D.O.B.:_____ Date:_____
Parent/Guardian:_____ Cell:_____ Other number: _____
Physician:_____ Phone number:_____
Medication Allergies: _____

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 Print Name: _____

Healthcare Provider Signature: _____ Date:_____