**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 bestPeak 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 neededOR□\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_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 \_\_\_\_\_minutesOR□\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_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 toself-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:\_\_\_\_\_\_\_\_\_\_ |