Red Oak I.S.D. Asthma Action Plan

Student Name:_____DOB:_____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 Name:_____
Healthcare Provider Signature:_____Date:_____