



Asthma Action Plan

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Name _____ DOB ____/____/____

Severity Classification Intermittent Mild Persistent Moderate Persistent Severe Persistent

Asthma Triggers (list)

Green Zone: Doing Well

Symptoms: Breathing is good – No cough or wheeze – Can work and play – Sleeps well at night

Control Medicine(s)	Medicine	How much to take	When and how often to take it
	_____	_____	_____
	_____	_____	_____

Physical Activity Use albuterol/levalbuterol _____ puffs 15-30 minutes before activity
 with all activity when you feel you need it

Yellow Zone: Caution

Symptoms: Some problems breathing – Cough, wheeze, or chest tight – Problems working or playing – Wake at night

Quick-relief Medicine(s) Albuterol/levalbuterol _____ puffs, every 4 hours as needed

Control Medicine(s) Continue Green Zone medicines
 Add _____ Change to _____

You should feel better within 20–60 minutes of the quick-relief treatment. If you are getting worse or are in the Yellow Zone for more than 24 hours, THEN follow the instructions in the RED ZONE and call the doctor right away!

Red Zone: Get Help Now!

Symptoms: Lots of problems breathing – Cannot work or play – Getting worse instead of better – Medicine is not helping

Take Quick-relief Medicine NOW! Albuterol/levalbuterol _____ puffs, _____ (how frequently)

Call 911 immediately if the following danger signs are present

- Trouble walking/talking due to shortness of breath
- Lips or fingernails are blue
- Still in the red zone after 15 minutes

Emergency Contact 1: _____
Name Phone Number Relationship

Emergency Contact 2: _____
Name Phone Number Relationship

Emergency Contact 3: _____
Name Phone Number Relationship

Parent Signature: _____ Date: _____

Nurse Signature: _____ Date: _____

Please contact the office at your child's school regarding the Medication Policies of the Ada City School District. If your child must take prescription or over-the-counter medication during the school day, he or she must have a current Medication Consent Form on file signed by a physician and a parent or guardian.

Asthma/ Reactive Airway Disease (RAD) Individual Health Plan (IHP)

Student's Name: _____ Date of Birth: _____

School: _____ Grade: _____ Homeroom Teacher: _____

Mother/Guardian: _____ Phone: _____

Father/Guardian: _____ Phone: _____

Doctor/Health Care Provider: _____ Phone: _____ Hospital _____

Carries own inhaler? Yes No Frequency of asthma episodes: _____ # of hospitalizations in last 12 months: _____

Assessment Data: (check or circle if applicable)

Signs/ Symptoms:	Triggers	Attendance Issues	Student Strengths
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Exercise <input type="checkbox"/> Chalk/markers	Y/N School	<input type="checkbox"/> has developed age appropriate self-management skills
<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Cold air <input type="checkbox"/> Perfumes	Y/N PE	<input type="checkbox"/> Good problem solving ability
<input type="checkbox"/> Chest tightness	<input type="checkbox"/> Dust <input type="checkbox"/> Smoke	Y/N Class	<input type="checkbox"/> Communicates needs
<input type="checkbox"/> Cough	<input type="checkbox"/> Stress <input type="checkbox"/> Air fresheners	Y/N Recess	<input type="checkbox"/> Accepts diagnosis
<input type="checkbox"/> Other (describe) _____	<input type="checkbox"/> Infection <input type="checkbox"/> Animals		<input type="checkbox"/> Effective coping skills
	<input type="checkbox"/> Allergies (describe): _____		<input type="checkbox"/> Good social skills
			<input type="checkbox"/> other: _____

Circle all that apply: Nursing diagnosis

Goals

<ol style="list-style-type: none"> 1. Potential for alteration in respiratory function 2. Potential for less than optimal school achievement d/t asthma. 3. Activity intolerance 4. Deficient knowledge 5. Ineffective airway clearance 6. other: 	<ol style="list-style-type: none"> 1. Increase knowledge &/or skills r/t asthma to maintain near normal pulmonary function. 2. Participate in regular school/class activities, including physical education class, with modifications made as necessary. 3. Effective management of asthma 4. Increased school attendance 5. Asthma will be controlled for optimum school participation
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Interventions: (check if applicable)

Loosen clothing Encourage relaxation Encourage pursed lip breathing

Administer medication Administer room temperature fluids by mouth if able to swallow

other _____

Asthma Education/ Self-Management Skills: Date

What is asthma?					Knowledge of triggers				
S/S warning signs					Techniques for staying active				
Correct inhaler technique					Medication review				
Correct neb technique					Other:				

Student Outcomes:

6. Student will participate in classroom/school activities with modifications as needed.
7. Student will improve or maintain understanding of checked items under Asthma Medication/ Self-Management skills
8. Student will identify symptoms and triggers.
9. Other (describe): _____

Plan reviewed: Date: _____

RN signature: _____