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Asthma Action Plan

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

	Name	Phone Number	Relationship
Emergency Contact 1:	_____	_____	_____
Emergency Contact 2:	_____	_____	_____
Emergency Contact 3:	_____	_____	_____

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 you 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
___Wheezing ___Difficulty Breathing ___Chest tightness ___ Cough ___Other (describe) _____	___Exercise ___Chalk/markers ___Cold air ___ Perfumes ___ Dust ___ Smoke ___ Stress ___ Air fresheners ___ Infection ___ Animals ___ Allergies (describe): _____	Y/N School Y/N PE Y/N Class Y/N Recess	___ has developed age appropriate self-management skills ___ Good problem solving ability ___ Communicates needs ___ Accepts diagnosis ___ Effective coping skills ___ Good social skills ___ other: _____

Circle all that apply: Nursing diagnosis	Goals
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:	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

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: _____