Beatrice Mayes Institute — Asthma Action Plan/ IHP

Date distributed and to whom: ______________________

Student's Name: ____________________ DOB: __________ Grade: ______ Medication Allergies: ____________________

Activities student participates in at school: ____________________

Asthma symptoms are triggered by: ☐ Exercise ☐Illness ☐Pollen ☐Smoke ☐Air Pollution ☐Animals ☐Cold Air ☐Molds ☐Foods (list)__________

Please list any other triggers: ____________________

Usual Asthma Symptoms: ☐Cough ☐Shortness of Breath ☐Chest Tightness ☐Wheeze ☐Other (list) __________

If a student has *any* of the following symptoms: chest tightness, difficulty breathing, wheezing, excessive coughing, shortness of breath:

1. **Stop activity & help student to a sitting position**
2. **Stay calm, reassure student**
3. **Assist student with the use of their inhaler**
4. **Escort student to the school clinic or call for nurse for immediate assistance. Never send the student to the clinic alone!**

INHALER IS KEPT: ☐ **In School Clinic** ☐ **Self Carry**

CALL 911 FOR ANY OF THESE!

- **If breathing does not improve after medication is given**
- **Student is having trouble walking or talking**
- **Student is struggling to breathe**
- **Student's chest and/ or neck is pulling in while breathing**
- **Student's lips are blue, and/ or**
- **Student must hunch over to breathe**

***HEALTH CARE PROVIDER*, *Please* complete *all* items in box:** **ICD Code: ☐ 493.9 or**__________

Asthma Severity: ☐ Intermittent ☐ Mild persistent ☐Moderate persistent ☐ Severe persistent

Controller Medication given at home:

____________________ Name of Medication 1/ how much? / How often?

____________________ Name of Medication 2/ how much? / How often?

GREEN ZONE

*Peak Flow__________
80 to 100% of personal best

Asthma Symptoms

- No Cough, wheeze or shortness of breath
- Able to do all normal activities including exercise and play
- No symptoms at night
- No need for quick relief medications for symptoms

Use daily controller medications. Use quick relief inhaler before exercise as ordered below:

____
Name of Medication 1/ how much? / How often?

YELLOW ZONE

*Peak Flow__________
50 to 80% of personal best

Asthma Symptoms

- Coughing, wheeze or shortness of breath, or chest tightness
- Using quick relief medication more than usual
- Can do some but not all of usual
- Asthma symptoms at night

Add or change medications (see below).

____
Name of Medication 1/ how much? / How often?

☐ 2 or ☐ 4 puffs, every 20 minutes for up to 1 hour

☐ Nebulizer __________

Parent/ guardian –call medical provider if using quick relief medication more than twice a week or no symptom improvement

RED ZONE

*Peak Flow__________
Less than 50% of personal best

Asthma Symptoms

- Medication unavailable or not working
- Getting worse not better
- Breathing hard and fast
- Chest/neck pulling in
- Difficulty walking or talking
- Lips or fingernails blue
- Hunched over to breathe

Take Quick Relief Medication Now!
***Call 911* & continue to give Quick Relief Medication every 20 minutes until EMS arrives!**

____________________ ☐ 4 ☐6 puffs
Name of Medication 1/ how much? / How often?
☐ Nebulizer __________

Other Emergency meds __________
Contact Parent & Provider-See Contact Info Below

Student can self carry medication? **Yes☐** **No ☐**

Student can self-administer medication? **Yes☐** **No☐**

Provider signature____________________ **Date**__________ **Provider printed name:** ____________________

Provider Phone ____________________ **Provider Fax:** __________ **Provider email** ____________________

*Peak flow reading may be obtained by the school RN in the school clinic. Implementation of these orders and care includes authorization to contact and discuss this conditions and elements of care with healthcare providers

I have reviewed this Health Care Plan and I give permission for my child to participate in asthma education classes & give consent to the nurse to discuss medical concerns with the physician.

Parent/ Guardian signature ____________________ Date: __________ Home Phone: __________ Cell phone __________

School Nurse Signature ____________________ Date: __________ Phone: __________ Fax: __________