

Sample (1) Asthma Action Plan



Asthma and Allergy
Foundation of America

STUDENT ASTHMA ACTION CARD



National Asthma Education and
Prevention Program



Name: _____ Grade: _____ Age: _____

Homeroom Teacher: _____ Room: _____

Parent/Guardian Name: _____ Ph: (h): _____

Address: _____ Ph: (w): _____

Parent/Guardian Name: _____ Ph: (h): _____

Address: _____ Ph: (w): _____

ID Photo

Emergency Phone Contact #1 _____

	Name	Relationship	Phone
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Emergency Phone Contact #2 _____

	Name	Relationship	Phone
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Physician Treating Student for Asthma: _____ Ph: _____

Other Physician: _____ Ph: _____

EMERGENCY PLAN

Emergency action is necessary when the student has symptoms such as, _____, _____, _____, _____ or has a peak flow reading of _____.

• Steps to take during an asthma episode:

1. Check peak flow.
2. Give medications as listed below. Student should respond to treatment in 15-20 minutes.
3. Contact parent/guardian if _____
4. Re-check peak flow.
5. Seek emergency medical care if the student has any of the following:
 - ✓ Coughs constantly
 - ✓ No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached.
 - ✓ Peak flow of _____
 - ✓ Hard time breathing with:
 - Chest and neck pulled in with breathing
 - Stooped body posture
 - Struggling or gasping
 - ✓ Trouble walking or talking
 - ✓ Stops playing and can't start activity again
 - ✓ Lips or fingernails are grey or blue

• Emergency Asthma Medications

	Name	Amount	When to Use
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

See reverse for more instructions

Sample (1) Asthma Action Plan (Continued)

DAILY ASTHMA MANAGEMENT PLAN

• Identify the things which start an asthma episode (Check each that applies to the student.)

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Strong odors or fumes | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Respiratory infections | <input type="checkbox"/> Chalk dust / dust | _____ |
| <input type="checkbox"/> Change in temperature | <input type="checkbox"/> Carpets in the room | |
| <input type="checkbox"/> Animals | <input type="checkbox"/> Pollens | |
| <input type="checkbox"/> Food _____ | <input type="checkbox"/> Molds | |

Comments _____

• Control of School Environment

(List any environmental control measures, pre-medications, and/or dietary restrictions that the student needs to prevent an asthma episode.) _____

• Peak Flow Monitoring

Personal Best Peak Flow number: _____

Monitoring Times: _____

• Daily Medication Plan

	Name	Amount	When to Use
1.	_____		
2.	_____		
3.	_____		
4.	_____		

COMMENTS / SPECIAL INSTRUCTIONS

FOR INHALED MEDICATIONS

- I have instructed _____ in the proper way to use his/her medications. It is my professional opinion that _____ should be allowed to carry and use that medication by him/herself.
- It is my professional opinion that _____ should not carry his/her inhaled medication by him/herself.

_____ Physician Signature	_____ Date
_____ Parent/Guardian Signature	_____ Date

Sample (2) Asthma Action Plan

ASTHMA ACTION PLAN FOR _____ Date _____

Doctor's Name _____

Hospital/Emergency Room Phone Number _____

Doctor's Phone Number _____

Take These Long-Term-Control Medicines Each Day (include an anti-inflammatory)		
Medicine	How much to take	When to take it

2 or 4 puffs 5 to 60 minutes before exercise

GREEN ZONE: Doing Well

- No cough, wheeze, chest tightness, or shortness of breath during the day or night
- Can do usual activities

And, if a peak flow meter is used,
Peak flow: more than _____
 (80% or more of my best peak flow)

My best peak flow is: _____

Before exercise

YELLOW ZONE: Asthma Is Getting Worse

FIRST

- Cough, wheeze, chest tightness, or shortness of breath, or
- Waking at night due to asthma, or
- Can do some, but not all, usual activities

-Or-

Peak flow: _____ to _____
 (50% - 80% of my best peak flow)

SECOND

Add: Quick-Relief Medicine - and keep taking your GREEN ZONE medicine

- 2 or 4 puffs, every 20 minutes for up to 1 hour
- Nebulizer, once

(short-acting beta₂-agonist)

If your symptoms (and peak flow, if used) return to GREEN ZONE after 1 hour of above treatment:

- Take the quick-relief medicine every 4 hours for 1 to 2 days.
- Double the dose of your inhaled steroid for _____ (7-10) days.

-Or-

If your symptoms (and peak flow, if used) do not return to GREEN ZONE after 1 hour of above treatment:

- Take: _____ 2 or 4 puffs or Nebulizer
 (short-acting beta₂-agonist)
- Add: _____ mg. per day For _____ (3-10) days
 (oral steroid)
- Call the doctor before/ within _____ hours after taking the oral steroid.

RED ZONE: Medical Alert!

- Very short of breath, or
- Quick-relief medicines have not helped, or
- Cannot do usual activities, or
- Symptoms are same or get worse after 24 hours in Yellow Zone

-Or-

Peak flow: less than _____
 (50% of my best peak flow)

DANGER SIGNS

- Trouble walking and talking due to shortness of breath
- Lips or fingernails are blue

- Take 4 or 6 puffs of your quick-relief medicine **AND**
- Go to the hospital or call for an ambulance (_____) **NOW!**