Must be completed by a **Licensed Health Professional**

School City of Hammond

Asthma Action Plan

Effective Date_____

Name: _____ DOB: _____ School: _____ Grade: _____

Parent Name(s): _____ Cell _____ Hm: _____ WK_____

Other Contacts: _____ Cell _____ Hm _____ WK:_____

Health Care Provider's Name: _____ PH: _____ Fax:_____

_____

THE AREAS BELOW ARE TO BE COMPLETED BY PHYSICIAN

Asthma is:

☐ Intermittent ☐ Persistent:

☐ Mild ☐ Moderate ☐ Severe

Asthma is:

☐ Well-Controlled ☐ Needs better control

What Triggers my Asthma(Things that make it worse):

☐ Colds ☐ Pollen ☐ Dust ☐ Smoke (tobacco, incense)

☐ Stress & emotions ☐ Exercise ☐ Gastric Reflux

☐ Mold/Moisture ☐ Animals:_____

☐ Strong Odors ☐ Other:_____

HOLDING CHAMBER/SPACER-to be used when taking inhaled medication: ☐ Yes ☐ No

SELF CARRY/ADMINISTER-in my opinion this child has the knowledge/skills to carry & self-administer the medicines below: ☐ Yes ☐ No

GREEN ZONE: GO!-Take these control medicines every day.

You have all of these:

- Breathing is good
- No cough or wheeze
- Can work/play easily
- Sleeping all Night

Peak Flow is in this area:
_____ or greater

Step 1: ☐ No control medicines required.

☐ Take these control medicine(s) every day:

_____ _____ _____
Inhaled medicine | Puffs | Frequency

_____ _____ _____
Medicine for Nebulizer Treatment | Dose | Frequency

Step 2: ☐ If exercise triggers Asthma, take the following medicine 15 minutes before exercise or sports. _____ _____
Inhaled Medicine | Puffs

YELLOW ZONE: CAUTION-Continue control meds & Add Quick Relief Medicine.

You have ANY of these:

- First sign of a cold
- Cough or mild wheeze
- Tight Chest
- Problems sleeping, working and or playing

Peak Flow is in this area:
_____ to _____

Step 1: ☐ Keep taking GREEN ZONE control meds and ADD quick relief medicine.

_____ _____ _____ _____
Inhaled Medicine | Dose(puffs) | Repeat (hrs) | Max. Treatments

OR ☐ Nebulizer Treatment(s)

_____ _____ _____ _____
Medicine: | Dose: | Repeat (hrs) | Max.Treatments

☐ Other:_____

Step 2: **If symptoms are getting worse, follow the RED ZONE instructions!**

RED ZONE: EMERGENCY-Get Help Now!

You have ANY of these:

- Hard to breathe
- Breathing hard and fast
- Trouble walking or talking
- Blue lips or fingernails
- Ribs show or nostrils open wide

Peak Flow is in this area:
_____ or less.

Step 1: ☐ Continue to take YELLOW ZONE medicine to maximum treatments.

☐ Add this medicine:

_____ _____ _____ _____
Inhaled Medicine | Dose (puffs) | Repeat (hrs) | Max. Treatments

Step 2: ☐ Call 911 ☐ Contact parent/ Guardian

Asthma Action Plan gives authorization for the treatment of Asthma at School. Medication will accompany student on field trips.

Physician Signature:_____ Date:_____

Parent/ Guardian Signature: _____ Date: _____

Health Service Staff Signature:_____ Date: _____

Must be completed by a
Licensed Health Professional

School City of Hammond

Asthma Action Plan Continued

Student's Name:_____ Date of Birth: _____ Effective Date_____

Additional Information:

_____

_____

_____

_____

_____

_____