American Lung Association.

# My Asthma **Action Plan**
## For Home and School

Name: _____ DOB: ____ / ____ / _____

Severity Classification: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Asthma Triggers (list): _____

Peak Flow Meter Personal Best: _____

### **Green Zone:** Doing Well

**Symptoms:** Breathing is good – No cough or wheeze – Can work and play – Sleeps well at night
**Peak Flow Meter** _____ (more than 80% of personal best)

**Flu Vaccine**—Date received: _____ Next flu vaccine due: _____ **COVID19 vaccine**—Date received: _____

| **Control Medicine(s)** | Medicine | How much to take | When and how often to take it | Take at |
|---|---|---|---|---|
| | | | | ☐ Home ☐ School |
| | | | | ☐ Home ☐ School |

**Physical Activity** ☐ Use Albuterol/Levalbuterol ____ puffs, 15 minutes before activity ☐ with all activity ☐ when you feel you need it

### **Yellow Zone:** Caution

**Symptoms:** Some problems breathing – Cough, wheeze, or tight chest – Problems working or playing – Wake at night
**Peak Flow Meter** _____ to _____ (between 50% and 79% of personal best)

**Quick-relief Medicine(s)** ☐ Albuterol/Levalbuterol ____ puffs, every 20 minutes for up to 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
**Peak Flow Meter** _____ (less than 50% of personal best)

**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

**School Staff: Follow the Yellow and Red Zone instructions for the quick-relief medicines according to asthma symptoms.**
The only control medicines to be administered in the school are those listed in the Green Zone with a check mark next to "Take at School".

☐ Both the Healthcare Provider and the Parent/Guardian feel that the child has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

**Healthcare Provider**
Name _____ Date _____ Phone (____) ____ - _____ Signature _____

**Parent/Guardian**
☐ I give permission for the medicines listed in the action plan to be administered in school by the nurse or other school staff as appropriate.
☐ I consent to communication between the prescribing health care provider or clinic, the school nurse, the school medical advisor and school-based health clinic providers necessary for asthma management and administration of this medicine.
Name _____ Date _____ Phone (____) ____ - _____ Signature _____

**School Nurse**
☐ The student has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.
Name _____ Date _____ Phone (____) ____ - _____ Signature _____

*Please send a signed copy back to the provider listed above.* **1-800-LUNGUSA | Lung.org**

*****Please see other side for more information and signatures.*****

**To be completed by Parent/Guardian/Caregiver:**

**Medications will only be administered to students in school by the school physician, certified or non-certified school nurse employed by the District, the student's parent, a student who is approved to self administer.**

I give permission for the school nurse to administer the prescribed medication. I will notify the nurse immediately if this medication is no longer required. The prescribed medication will be provided by me in the original container with the appropriate pharmacy label and kept in the nurse office. The school nurse has my permission to contact the prescriber directly for questions regarding the medication or diagnosis.

I shall indemnify and hold harmless the Island Heights School District and its employees or agents for legal fees, costs, and any potential damages concerning the use of the medication arising out of any claims brought by the above named child or anyone else.

I further understand that this permission is effective for the school year for which it is granted and must be renewed for each subsequent school year upon fulfillment of requirements set by the board.

**Parent/Guardian signature** **Date**