Educational Service Center of Medina County
"Stepping Up to Excellence"

Student Photo ID

Asthma Action Plan

Student's Name:	Date of Birth:
Contact Teacher:	School/Grade:
Parent/Guardian Name:	Phone (Family):
Address:	
Emergency Number:	Relationship:
Asthma Specialist:	Office Phone:
Family Physician:	Office Phone:

Please indicate (circle one): with / without spacer   Pulse oximeter range: ____________________

____________________ has demonstrated proper use and inhaler technique and should be allowed to carry and use his/her asthma inhaler(s) by himself/herself.
(Student name)

____________________ will need assistance with his/her asthma inhaler(s) and should be kept by the school teacher or personnel but must be given immediately for asthma symptoms.
(Student name)

GREEN ZONE: I AM MEETING MY ASTHMA GOALS

THE GREEN ZONE SHOULD BE YOUR GOAL EVERY DAY.

Symptoms:
- No coughing, shortness of breath, wheezing, or chest tightness
- Sleeping all night
- Can do all usual activities (work, play)

Action Plan:
- Avoid triggers or things that make my asthma worse, like: ☐ Mold/Pollens ☐ Animals ☐ Colds ☐ Dust ☐ Exercise ☐ Smoke ☐ Weather ☐ Fragrance ☐ Other ____________________

MEDICINE(S):	HOW MUCH:	WHEN:

Before exercise:

MEDICINE:	HOW MUCH:	WHEN:

YELLOW ZONE: CAUTION, MY ASTHMA SYMPTOMS ARE GETTING WORSE

Symptoms:
- Some problems with coughing, shortness of breath, wheezing, or chest tightness OR
- Waking up at night due to asthma OR
- Using more quick-relief asthma medicine OR
- Can do some, but not all, usual activities (work, play)

Action Plan:
- Keep taking my asthma medicine as directed by my doctor, including my quick-relief medicine

MEDICINE(S):	HOW MUCH:	WHEN:

RED ZONE: I AM HAVING SERIOUS SYMPTOMS. I NEED TO CALL MY DOCTOR OR CALL 911 NOW!

Symptoms:

- Cannot stop coughing
- Getting worse, instead of better
- Lips or fingernails are blue
- The skin between the ribs and above the collarbone pulls in or retracts
- Breathing fast
- Flaring nostrils
- Medication not helping
- Trouble walking or talking from shortness of breath

Action Plan:

- CONTACT A DOCTOR IMMEDIATELY
- Take my quick-relief asthma medicine as directed by my doctor

MEDICINE(S):	HOW MUCH:	WHEN:

CALL 911 IF YOU ARE IN THE RED ZONE AND HAVING DANGER SIGNS SUCH AS:

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

This plan is subject to change, but only with documentation from physician along with meeting with parents and staff. This plan will be shared with all teachers, support staff, and transportation staff who are involved with student's school day.

I am in agreement with this plan of care and understand it will be shared as needed with members of the school staff to safeguard and promote the health of the student listed above while at school. I will notify the school immediately: 1) if the health status of the student listed above changes, 2) we change physicians, or 3) there is a change or cancellation of the physician's orders.

Parent/Legal Guardian ______________________________ Date ____________________

Parent/Legal Guardian ______________________________ Date ____________________

Registered Nurse ______________________________ Date ____________________

MEDICAL REVIEW

I have reviewed the Asthma Action Plan (AAP) for __________________________, and:

________ I approve the AAP as written.

________ I approve the AAP with the attached amendments.

________ I do not approve of the AAP as written, and substitute orders are attached.

Physician ______________________________ Date ____________________

Other Recommendations: ____

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Copies to:

☐ Board Office ☐ Bus Garage ☐ Teacher ☐ Other ____________________