Tuscarora School District

Asthma Action Plan

School Year_________
Bus # _________

Student Name: ________________________________ DOB__________

Grade_____ Homeroom teacher ______________________________

Emergency Contacts:

Name ______________________________ Daytime Phone # ______________________________

DAILY ASTHMA TREATMENT AND EMERGENCY PLAN

Medical Equipment:

Please list any medical equipment this student will need to treat his/her asthma at school (i.e. spacer, nebulizer supplies, oxygen, etc.). *Parent will provide equipment needed:*

____

____

GREEN ZONE – Peak flows ______ to ______ *No symptoms (peak flow between 80-100% of personal best)*

For Asthma with exercise: ______ puff(s) ________________________________ 15 minutes before exercise.

YELLOW ZONE- Peak flows _____ to _____ *Tight chest, cough, or mild wheeze, signs of upper respiratory illness, unable to exercise (peak flow between 50-80% of personal best.*

_____puff(s) ____________________ MDI every _____ hours as needed OR

________________________________ nebulizer treatment(s) every ______ hours as needed

RED ZONE- Peak flows below ________ *(peak flow less than 50% of personal best):* **EMERGENCY ACTION IS NECESSARY WHEN THIS TUDENT HAS SYMPTOMS SUCH AS:**

Can't talk, eat, or walk well — Medicine is not helping — Chest/neck retractions

Breathing hard & fast — Blue lips and/or fingernails

_____ puffs ________________________ MDI every __________ minutes for _____ treatments

OR ________________________nebulizer treatment every _____ minutes for ______treatments

Contact Parent________ Contact 911________

Comments and/or special instructions: ______________________________________

Student is allowed to self-administer inhaler and carry inhaler during school hours ____Yes ___No

____

PHYSICIAN SIGNATURE DATE

____

PARENT SIGNATURE DATE

Background Information

_____Asthma is intermittent OR

_____Asthma is _____ Persistent _____Mild ___Moderate____ Severe

TRIGGERS

___Colds	___Pollen	___Dust	___Animals ____________________

___Smoke	___Pests (rodents, cockroaches)	___Stress

___Exercise	___Gastroesophageal reflux	___Strong odors

___Seasonal ____________________	___Other____________________

Asthma Control:

___Well controlled	___Needs better control

Has the student ever experienced a severe asthma episode in the past that required emergency room care or hospitalization? What care was needed at the time?____________________

____

Medications at home

1.

2.

3.

4.

5.

6.

Physician and Parent/Guardian to fill out care plan and return to school nurse.