Asthma Action Plan

AMERICAN LUNG ASSOCIATION.

General Information:

- Name _____
- Emergency contact _____ Phone numbers _____
- Physician/healthcare provider _____ Phone numbers _____
- Physician signature _____ Date _____

Severity Classification

- O Intermittent
- O Mild Persistent
- O Moderate Persistent
- O Severe Persistent

Triggers

- O Colds
- O Smoke
- O Weather
- O Exercise
- O Dust
- O Air Pollution
- O Animals
- O Food
- O Other _____

Exercise

1. Premedication (how much and when) _____
2. Exercise modifications _____

Green Zone: Doing Well

Peak Flow Meter Personal Best =

Symptoms

- Breathing is good
- No cough or wheeze
- Can work and play
- Sleeps well at night

Control Medications:

Medicine	How Much to Take	When to Take It

Peak Flow Meter

More than 80% of personal best or _____

Yellow Zone: Getting Worse

Contact physician if using quick relief more than 2 times per week.

Symptoms

- Some problems breathing
- Cough, wheeze, or chest tight
- Problems working or playing
- Wake at night

Continue control medicines and add:

Medicine	How Much to Take	When to Take It

Peak Flow Meter

Between 50% and 80% of personal best or _____ to _____

IF your symptoms (and peak flow, if used) return to Green Zone after one hour of the quick-relief treatment, THEN

- O Take quick-relief medication every 4 hours for 1 to 2 days.
- O Change your long-term control medicine by _____
- O Contact your physician for follow-up care.

IF your symptoms (and peak flow, if used) DO NOT return to Green Zone after one hour of the quick-relief treatment, THEN

- O Take quick-relief treatment again.
- O Change your long-term control medicine by _____
- O Call your physician/Healthcare provider within ____ hour(s) of modifying your medication routine.

Red Zone: Medical Alert

Ambulance/Emergency Phone Number:

Symptoms

- Lots of problems breathing
- Cannot work or play
- Getting worse instead of better
- Medicine is not helping

Continue control medicines and add:

Medicine	How Much to Take	When to Take It

Peak Flow Meter

Less than 50% of personal best or _____ to _____

Go to the hospital or call for an ambulance if:

- O Still in the red zone after 15 minutes.
- O You have not been able to reach your physician/healthcare provider for help.
- O _____

Call an ambulance immediately if the following danger signs are present:

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

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Inhaler use - Please complete this form, the action plan on back & provide a copy of the inhaler's prescription label for your child. A doctor's signature is no longer needed.

RED BUD SCHOOL DISTRICT #132
SELF ADMINISTRATION OF MEDICATION

DATE_____ NAME_____
MEDICATION_____
DOSE_____ FREQUENCY_____

Public Act 92-0402 allows public school students with asthma/severe allergies to carry and self-administer prescribed asthma and/or epinephrine auto-injector devices. State law requires the school district to inform the parents or guardians of the student, in writing, that the school district and its employees and agents are to incur no liability, except for willing and wanton conduct, as a result of any injury arising from the self-administration of medication by the student.

Prior to allowing your child to carry and self-administer the medication, a copy of this form must be signed by the parent or guardian and returned to the child's school nurse.

The permission for self-administration of asthma/severe allergy medication is effective for the school year for which it is granted. It shall be renewed each school year as required for health purposes. This student may possess and use his/her medication while in school, at school-sponsored activity, while under the supervision of school personnel, or before or after normal school activities. The district recommends you provide an additional dose of medication to be kept at school in the event your child forgets or misplaces his/her medication.

As parent or guardian of _____, I acknowledge that Red Bud School District #132 and its employees and agents are to incur no liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of medication by the above named student. I indemnify and hold harmless the school district and its employees against any claims, except a claim based on willful and wanton conduct, arising out of the self-administration of medication by the student. I believe this child to be knowledgeable and capable to self-administer this medication without supervision.

PARENT
SIGNATURE_____ DATE_____

ALONG WITH THIS FORM THE PARENT/GUARDIAN MUST PROVIDE THE SCHOOL WITH THE PRESCIPTION LABEL, WHICH MUST CONTAIN THE STUDENT'S NAME, NAME OF THE MEDICATION, DOSAGE, TIME AND CIRCUMSTANCES IN WHICH THE MEDICATION IS TO BE ADMINISTERED.

Asthma

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