ASTHMA ASSESSMENT AND ACTION PLAN

Date: _____

Child's Name: _____ **Birthdate:**_____ **Age:**_____

Classroom: _____

DAILY ASTHMA ACTION PLAN

- **Check all of the things which may start an asthma episode in your child:**

❑ **Exercise**	❑ **Strong odors or fumes**	❑ **Other**_____
❑ **Respiratory infections**	❑ **Chalk dust**	
❑ **Change in temperature**	❑ **Carpets in the room**	
❑ **Animals**	❑ **Pollens**	
❑ **Food**_____	❑ **Molds**	

- **List any environmental control measures, pre-medications, and/or dietary restrictions that your child needs to prevent an asthma episode:**

_____

_____

- **Peak Flow Monitoring**:

  Personal Best Peak Flow Number:_____

  Monitoring Times:_____

- **Daily Medication Plan (taken at home):**
  GREEN ZONE- No asthma symptoms, able to do all activities, or medication to prevent exercise induced asthma

Name **Dosage**

1._____
2._____
3._____

YELLOW ZONE: asthma symptoms-cough, wheeze, short of breath, limited activities

Emergency action is necessary when your child has the following symptoms:_____

_____.

Emergency action is necessary when your child has a peak flow reading of:_____.

- **Steps to take during an asthma episode:**
  1. **Give rescue medications listed below**
  2. **Have child return to classroom if_____**
  3. **Contact parent if_____**
  4. **Seek emergency medical care (CALL 911) if the student has any of the following:**

RED ZONE:

- **No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached.**
- **Peak flow of_____**
- **Fast or Hard time breathing with:**
  - **Chest and neck pulled in with breathing**
  - **Child is hunched over**
  - **Child is struggling to breathe**
- **Trouble walking or talking**
- **Stops playing and can't start activity again**
- **Lips or fingernails are gray or blue**

- **Emergency Asthma Medications to be Taken at School (requires medication authorization on file):**

Name	Dosage	Exp. Date	When to Use
1.			
2.			
3.			
4.			

Dr. Name:	**Dr. Phone #:**
Dr. Signature:	**Date:**

Has the child been instructed in:

_____Warning signs/symptoms of asthma attack?_____Use of inhaler_____Use of Peak Flow Meter?

_____ _____

Parent Signature Date