ASTHMA EMERGENCY ACTION PLAN

SHARYLAND ISD HEALTH SERVICES

Place child's picture here

Student Name: _____ DOB: _____/_____/_____ ID#_____

School: _____ Grade/Teacher (if elem.): _____

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)

Control Medicine(s)	How much to take	When & how often to take it	Take it at:
_____			□ Home □ School
_____			□ Home □ School

Physical activity: Use Albuterol/Levalbuterol, (# of puffs)→_____ □ 15 minutes before P.E. □ Specify if longer than 15 min→ _____ min

Check other if apply: □ With all activity (Has it been at least 4 hours since last dose?) □ When the child feels he/she needs it

Yellow Zone: Caution

Symptoms: Some problems breathing – Cough, wheeze, or chest tightness – Problems working or playing – Wake at night
Peak flow meter _____ to _____ (between 50% and 79% personal best)

Quick relief medicine(s): □ Albuterol/Levalbuterol _____ puffs, every 4 hours as needed ***OR*** _____

Control Medicine(s): □ Continue Green Zone medicines

□ Add _____ □ Change to _____

The child should feel better within 20-60 minutes of the quick-relief treatment. If the child is getting worse or is 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 not helping
Peak flow meter _____ (less than 50% of personal best)

Take Quick relief medicine NOW! □ Albuterol/Levalbuterol (# of puffs)→ _____ How frequently? _____

***CALL 911 immediately if the following danger signs are present**: Up to how many times? _____

*No relief from inhaler, persistent shortness of breath (breathlessness), blue lips/fingernails, straining to breathe, unable to speak, chest tightness, feelings of agitation/confusion/inability to concentrate, hunching of shoulders, straining abdominal/neck muscles, sitting/standing to breathe more easily

□ Administer epinephrine auto-injector (if available) for the following: _____

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".

Healthcare Provider (Texas-Licensed Physician)- SIGNATURE REQUIRED

Signature _____ PRINT Name _____ Date: ___/___/20___ Phone ( ) _____

FOR STUDENT TO CARRY & SELF-ADMINISTER; Initial Yes or No below.

Both I and the parent/guardian believe, the child has demonstrated the knowledge and 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.

_____ Yes _____ No ***Note*:** An extra inhaler should be kept in the nurse's clinic in the event the inhaler is lost or stolen from.

Parent/Guardian- SIGNATURE REQUIRED

_____ 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 and to communication between the prescribing healthcare provider/clinic and the school nurse for necessary asthma management and administration of this medicine.

Signature _____ PRINT Name _____ Date: _____/_____/20___ Phone ( ) _____

School Nurse-SIGNATURE REQUIRED

Signature _____ PRINT Name _____ Date: _____/_____/20___ Phone ( ) _____

IF STUDENT WILL CARRY & SELF-ADMINISTER: □ The student has demonstrated, in clinic, the knowledge and 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.

Nurse initials: _____ Date: _____/_____/20___

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AMERICAN LUNG ASSOCIATION.