# Asthma Action Plan

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**Name** ______________________________________________ **DOB** ______ /______ /____________

**Severity Classification** ○ Intermittent ○ Mild Persistent ○ Moderate ○ Persistent ○ Severe Persistent

**Asthma Triggers** (list)

____________________________________________________________________________________

____________________________________________________________________________________

## Green Zone: Doing Well

**Symptoms: Breathing is good – No cough or wheeze – Can work and play – Sleeps well at night**

| Control Medicine(s) | Medicine | How much to take | When and how often to take it |
| --- | --- | --- | --- |
| | ______________ | ________________ | ____________________ |
| | ______________ | ________________ | ____________________ |

**Physical Activity** ○ Use albuterol/levalbuterol _____ puffs 15-30 minutes before activity
○ with all activity ○ when you feel you need it

## Yellow Zone: Caution

**Symptoms: Some problems breathing – Cough, wheeze, or chest tight – Problems working or playing – Wake at night**

**Quick-relief** Medicine**(s)** ○ Albuterol/levalbuterol _____ puffs, every 4 hours as needed

**Control** Medicine**(s)** ○ Continue Green Zone medicines
○ Add ______________________ ○ Change to __________________

**You should feel better within 20–60 minutes of the quick-relief treatment. If you are getting worse or are 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 is not helping**

**Take Quick-relief Medicine NOW!** ○ Albuterol/levalbuterol _____ puffs, _____________(how frequently)

**Call 911 immediately if the following danger signs are present**
- Trouble walking/talking due to shortness of breath
- Lips or fingernails are blue
- Still in the red zone after 15 minutes

Emergency Contact 1: ______________________ ______________________ ______________________
Name Phone Number Relationship

Emergency Contact 2: ______________________ ______________________ ______________________
Name Phone Number Relationship

Emergency Contact 3: ______________________ ______________________ ______________________
Name Phone Number Relationship

Parent Signature: _____________________________________________ Date: ___________________

Nurse Signature: ______________________________________________ Date: ___________________

Please contact the office at your child's school regarding the Medication Policies of the Ada City School District. If you child must take prescription or over-the-counter medication during the school day, he or she must have a current Medication Consent Form on file signed by a physician and a parent or guardian.

# Asthma/ Reactive Airway Disease (RAD) Individual Health Plan (IHP)

Student's Name: ______________________________________________________ Date of Birth: _______________________________

School: _____________________________ Grade: _________ Homeroom Teacher: __________________________________________

Mother/Guardian: ____________________________________________________________ Phone: ______________________________

Father/Guardian: ___________________________________________________________ Phone: _______________________________

Doctor/Health Care Provider: _____________________________ Phone: ________________ Hospital _________________________

Carries own inhaler? ___Yes ___No Frequency of asthma episodes: ________ # of hospitalizations in last 12 months: ______

**Assessment Data:** (check or circle if applicable)

| **Signs/ Symptoms:** | **Triggers** | | **Attendance Issues** | **Student Strengths** |
|---|---|---|---|---|
| ___Wheezing | ___Exercise | ___Chalk/markers | Y/N School | ___ has developed age appropriate self-management skills |
| ___Difficulty Breathing | ___Cold air | ___ Perfumes | Y/N PE | ___ Good problem solving ability |
| ___Chest tightness | ___ Dust | ___ Smoke | Y/N Class | ___ Communicates needs |
| ___ Cough | ___ Stress | ___ Air fresheners | Y/N Recess | ___ Accepts diagnosis |
| ___Other (describe) | ___ Infection | ___ Animals | | ___ Effective coping skills |
| ______________________ | ___ Allergies (describe): | | | ___ Good social skills |
| | ________________________________ | | | ___ other: ___________________ |

**Circle all that apply:**

| **Nursing diagnosis** | **Goals** |
|---|---|
| 1. Potential for alteration in respiratory function<br>2. Potential for less than optimal school achievement d/t asthma.<br>3. Activity intolerance<br>4. Deficient knowledge<br>5. Ineffective airway clearance<br>6. other: | 1. Increase knowledge &/or skills r/t asthma to maintain near normal pulmonary function.<br>2. Participate in regular school/class activities, including physical education class, with modifications made as necessary.<br>3. Effective management of asthma<br>4. Increased school attendance<br>5. Asthma will be controlled for optimum school participation |

**Interventions:** (check if applicable)

____Loosen clothing ___Encourage relaxation ___Encourage pursed lip breathing

___ Administer medication ___ Administer room temperature fluids by mouth if able to swallow

___ other ____________________________________________________________________________________________

**Asthma Education/ Self-Management Skills: Date**

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| What is asthma? | | | | | Knowledge of triggers | | | | |
| S/S warning signs | | | | | Techniques for staying active | | | | |
| Correct inhaler technique | | | | | Medication review | | | | |
| Correct neb technique | | | | | Other: | | | | |

**Student Outcomes:**

6. Student will participate in classroom/school activities with modifications as needed.
7. Student will improve or maintain understanding of checked items under Asthma Medication/ Self-Management skills
8. Student will identify symptoms and triggers.
9. Other (describe): ____________________________________________________________________________________

Plan reviewed: Date: ________________ RN signature: _________________________________________________________