Donna I.S.D. Health Services

SCHOOL YEAR 20_____-20_____ **ASTHMA ACTION PLAN** **Date:_____**

DIAGNOSIS: Asthma Severity (*Select one*): ☐Intermittent:☐Exercise Induced Asthma/Bronchoconstriction
☐Persistent: ☐Mild; ☐Moderate; ☐Severe

RESCUE MEDICATION: ☐Proventil HFA; ☐Ventolin HFA; ☐Xopenex HFA; ☐ProAir HFA; ☐ProAir RespiClick; ☐Nebulizer

PREVENTATIVE MEDICATION (*taken at home*): _____ ☐Inhaler ☐Diskus
#_____Inhalations/Puffs _____times a day; Other:_____

What triggers my asthma: ☐Smoke ☐Mold ☐Tree/Grass/Weed Pollen ☐Cold/Virus ☐Exercise ☐Seasons ☐Other:_____

GREEN ZONE: DOING WELL	**YELLOW ZONE:** ASTHMA GETTING WORSE	**RED ZONE:** MEDICAL ALERT
If no cough, wheeze, chest tightness or shortness of breath during the day/night and can do usual activities, ***then***: **Take as Needed *before* exercise**: 2 puffs of Rescue Medication 5-15 mins before exercise 	**If** cough, wheeze, chest tightness or shortness of breath; waking at night due to asthma; or can do some but not all usual activities, ***then***: **TAKE** rescue inhaler dose 2-4 puffs every 20 mins for up to 1 hour as needed for cough, wheeze, shortness of breath or chest tightness. ***or:*** *Nebulizer*, once or up to every 20 mins for up to 1 hour for cough, wheeze, shortness of breath or chest tightness. ***Call the healthcare Provider within 24 hours if asthma symptoms do not improve*** **IF AT SCHOOL:** Return student to classroom if stable & symptoms return to green zone *and* continue monitoring to be sure student remains in GREEN ZONE Or if symptoms do not return to GREEN ZONE after 1 hour of treatment: **TAKE**: Rescue Inhaler 2-4 puffs and ***CALL*** parent and health care provider.	***IF ONE OR MORE OF THE FOLLOWING ARE PRESENT:*** • Coughing, wheezing, shortness of breath, not helped with medications • Hard time breathing with chest and neck pulled in with breathing: Child is hunched over • Trouble walking or talking due to shortness of breath • Stops playing and cannot start activity again • Lips or fingernails are grey or blue ***then***: **TAKE RESCUE INHALER 4-6 inhalations or nebulizer. Call 911, parent and healthcare provider. Repeat the dose if not improved in 15-20 mins.**  

Name:_____DOB:_____ School:_____ Fax_____
Health Care Provider #:_____Fax:_____ Emergency #:911 *OR*_____

(*Circle one*) Patient ***MAY / MAY NOT*** be allowed to carry and self-administer rescue inhaler.

☐I authorize health information sharing on my child with relevant school officials and healthcare providers.
☐*Autorizo a la información de salud compartiendo en mi hijo/hija con las autoridades escolares competentes y profesionales de la salud.*

Parent/Guardian Signature
x_____

Physician/ Healthcare Provider Signature
x_____