Intermediate School District 917
Asthma Action Plan

Name _____ **Weight** _____ **Birth date** _____ **Peak Flow** _____
Dx _____ **ICD-10** _____
Dx _____ **ICD-10** _____

Asthma Severity _____

Symptom Triggers _____ **Primary Clinic Name** _____
Primary Care Provider Name _____ **Phone** _____ **Fax** _____

PLEASE also complete an ñAuthorization and Request for Administration of Medicationsò

Green Zone
"Go! All Clear!"

Peak Flow Range
(80-100% of personal best)

_____ to _____

-Breathing is easy
-Can play, work and sleep without asthma symptoms

The **Green Zone** means take the following medicine(s) every day.

Controller Medicine(s) **Dose**

_____
_____

Spacer Used _____

Child to take the following medicine if needed 10-20 minutes before sports, exercise, or any other strenuous activity

_____

Yellow Zone
"Caution..."

Peak Flow Range
(50-80% of personal best)

_____ to _____

-Wake up at night

-Cough or wheeze

-Chest is tight

The **Yellow Zone** means the child is to keep taking his/her Green Zone controller medicine(s) every day and add the following medicine(s) to help keep the asthma symptoms from getting worse.

Reliever Medicine(s) **Dose**

_____
_____

If seeing beginning cold symptoms, call the childõs doctor before starting oral steroids.

Use Quick Reliever 2-4 puffs every 20 minutes for up to 1 hour, or use nebulizer once. If symptoms are not better or the child does not return to the GREEN ZONE after 1 hour, follow RED ZONE instructions. If the child's breathing symptoms get worse, call parent and/or the child's provider.

Red Zone
"STOP!"
"Medical Alert!"

Peak Flow Range
(Below 50% of personal best)

_____ to _____

-Medicine is not helping
-Nose opens wide to breathe
-Breathing is hard and fast
-Trouble walking
-Trouble talking
-Ribs show

The **Red Zone** means the child is to start taking his/her Red Zone medicine(s) and call the childõs doctor NOW! Give these medicines until talking to the childõs doctor. If the childõs symptoms do not get better and the doctor can't be reached, **call parent and 911 immediately**.

Reliever Medicine(s) **Dose**

_____
_____
_____

I give my permission for this asthma action plan to be used by the following individuals, and for them to share information with each other about my child's asthma up to one year beginning today, so that they can work together to help my child manage his/her asthma. This plan, when signed and dated, may replace or supplement the school's/daycare's consent-to-administer medication form, and allows my child's medicine to be administered at school/daycare.

- ❑ My child's school Health Office _____ My child's daycare provider _____
- ❑ Student may carry and use the medicine(s) noted above at school after approval by the School Nurse.
- ❑ My child is allowed to self-administer medications.

Parent/Guardian Signature _____ **Date** _____

MD/NP/PA Signature _____ **Date** _____

For office use only:
LSN Signature _____ Date _____
Name of Staff Routing _____ Date _____
Please check off who was routed this form ___Student File _____ IEP Manager ___ 917 LSN ___Building Nurse ___ Transportation
___ Bus Driver ___ Spec Ed Vans