GARLAND INDEPENDENT SCHOOL DISTRICT
Health Services
Asthma Action Plan

Name	Date of Birth	ID #
Parent / Guardian	Parent / Guardian Phone	
Additional Emergency Contact	Contact Phone	

Asthma Triggers (Things that make your asthma worse)

☐ Colds ☐ Dust ☐ Animals: _____ ☐ Strong odors Season
☐ Smoke (tobacco, incense) ☐ Acid reflux ☐ Pests (rodents, cockroaches) ☐ Mold / Moisture ☐ Fall ☐ Spring
☐ Pollen ☐ Exercise ☐ Other: _____ ☐ Stress / Emotions ☐ Winter ☐ Summer

▼ Medical Provider complete from here down ▼

Asthma Severity: ☐ Intermittent or ☐ Persistent: ☐ Mild ☐ Moderate ☐ Severe

Green Zone: Go!

You have **ALL** of these:

- Breathing is easy
- No cough or wheeze
- Can work and play
- Can sleep all night

Peak flow: _____ to _____
(More than 80% of Personal Best)
Personal best peak flow: _____

Take these CONTROL (PREVENTION) Medicines EVERY Day

Always rinse your mouth after using your inhaler and remember to use a spacer with your MDI.

☐ No control medicines required
☐ Advair ☐ Alvesco ☐ Asmanex ☐ Dulera
☐ Flovent ☐ Pulmicort ☐ QVAR ☐ Symbicort
☐ Other: _____

_____ puff (s) MDI _____ times a day **Or** _____ nebulizer treatment (s) _____ times a day

☐ (Montelukast) Singulair, take _____ by mouth once daily at bedtime
For asthma with exercise, ADD: ☐ Albuterol ☐ Xopenex ☐ Ipratropium (Atrovent)
MDI, **2** puffs with spacer 15 minutes before exercise (i.e., PE class, recess, sports)

Yellow Zone: Caution!

You have **ANY** of these:

- Cough or mild wheeze
- First sign of cold
- Tight chest
- Problems sleeping, working, or playing

Peak flow: _____ to _____
(50% - 80% of Personal Best)

Continue CONTROL Medicines and ADD RESCUE Medicines

☐ Albuterol ☐ Levalbuterol (Xopenex) ☐ Maxair ☐ Ipratropium (Atrovent)
MDI _____ puffs with spacer every _____ hours as needed
☐ Albuterol 2.5 mg/3ml ☐ Levalbuterol (Xopenex) _____ ☐ Ipratropium (Atrovent) 2.5 mg/3ml
one nebulizer treatment every _____ hours as needed

☐ Other: _____

Call your Healthcare Provider if you need rescue medicine for more than 24 hours or two times a week, or if your rescue medicine doesn't work.

Red Zone: DANGER!

You have **ANY** of these:

- Can't talk, eat or walk well
- Medicine is not helping
- Breathing hard and fast
- Blue lips and fingernails
- Tired or lethargic
- Chest / neck retractions

Peak flow: < _____
(Less than 50% of Personal Best)

Continue CONTROL & RESCUE Medicines and GET HELP!

☐ Albuterol ☐ Levalbuterol (Xopenex) ☐ Ipratropium (Atrovent)
MDI _____ puffs with spacer **every 15 minutes**, for **THREE** treatments
☐ Albuterol 2.5 mg/3ml ☐ Levalbuterol (Xopenex) _____ ☐ Ipratropium (Atrovent) 2.5 mg/3ml
one nebulizer treatment **every 15 minutes**, for **THREE** treatments
☐ Other: _____

Call your doctor while administering the treatments.
IF YOU CANNOT CONTACT YOUR DOCTOR:
Call 911 or go directly to the Emergency Department NOW!

Required Signatures:

Physician Name (Print)	Phone Number
Physician Signature	Date

I give permission for school personnel to follow this plan, administer medication and care for my child and contact my provider if necessary. I assume full responsibility for providing the school with prescribed medication and delivery / monitoring devices. I approve this Asthma Management Plan for my child.

Parent / Guardian Signature	Date
School Nurse	Date

For OFFICE use only: ☐Med entered in EMR ☐Scanned and uploaded ☐Updated Health Condition ☐Update/create IHP