My Asthma Action Plan

SCHNECK

Name: _____ DOB: _____ Date: _____

Doctor Phone: _____ Emergency Contact Phone: _____

TO BE COMPLETED BY ASTHMA CARE PROVIDER

RESCUE (quick-relief) MEDICATION: _____

	MONITORING	TREATMENT
RED	**RED ZONE: DANGER SIGNS** • Very short of breath, or • Rescue medicines have not helped, or • Cannot do usual activities, or • Symptoms are same or get worse after 24 hours in Yellow Zone **RED ZONE: EMERGENCY SIGNS** • Lips and fingernails are blue and gray • Trouble walking and talking due to shortness of breath • Loss of consciousness	• Give rescue medication: ☐ 2 ☐ 4 ☐ 6 puffs (1 min. between puffs) or 1 nebulizer treatment • Call Asthma Care provider • **Call 911 NOW if:** 1. Unable to reach Asthma Care provider after arriving in the red zone. 2. Struggling to breathe and there is no improvement after taking albuterol. 3. May repeat rescue medication every 10 minutes if symptoms do not improve, until medical assistance has arrived or you are at the emergency department.
YELLOW	**YELLOW ZONE: CAUTION** • Cough, wheeze, chest tightness, or shortness of breath, or • Waking at night due to asthma, or • Can do some, but not all, usual activities	• Continue daily controller medications • Give rescue medication: ☐ 2 ☐ 4 ☐ 6 puffs (1 min. between puffs) or 1 nebulizer treatment every 4 hours as needed • Wait 10 minutes and recheck symptoms • **If not better, go to RED ZONE** • **If symptoms improve, may return to normal activity, or** _____ _____ • If needed, coordinate rescue medications to be given every 4 hours for ☐ 2 ☐ 3 days, if symptoms remain improved • If symptoms are not gone after ☐ 2 ☐ 3 days, move to **RED ZONE**
GREEN	**GREEN ZONE: WELL** • No cough, wheeze, chest tightness, or shortness of breath during the day or night • Can do usual activities and sleep without having symptoms • Avoid known triggers: _____ _____ _____	

MEDICATION	HOW MUCH	WHEN
DAILY CONTROLLER MEDICATION	**HOW MUCH**	**WHEN**

FOR PEDIATRIC PATIENTS

☐ Administer medications as instructed above
☐ Student has been instructed in the proper use of all asthma medications, and in my opinion, can carry and use inhaler at school
☐ Student needs supervision or assistance to use inhaler medication
☐ Student should **NOT** carry inhaler while at school

_____ _____ _____
ASTHMA CARE PROVIDER SIGNATURE **PRINT PROVIDER NAME** **DATE**

I give my permission for the school nurse and any pertinent staff caring for my child to follow this plan, administer medication and care for my child, contact my asthma care provider if necessary, and for this form to be faxed/emailed to my child's school or be shared with school staff per FERPA guidelines. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices.

_____ _____
PARENT SIGNATURE **DATE**