



## ASTHMA ASSESSMENT AND ACTION PLAN

Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

Classroom: \_\_\_\_\_

### DAILY ASTHMA ACTION PLAN

- Check all of the things which may start an asthma episode in your child:

<input type="checkbox"/> Exercise	<input type="checkbox"/> Strong odors or fumes	<input type="checkbox"/> Other _____
<input type="checkbox"/> Respiratory infections	<input type="checkbox"/> Chalk dust	
<input type="checkbox"/> Change in temperature	<input type="checkbox"/> Carpets in the room	
<input type="checkbox"/> Animals	<input type="checkbox"/> Pollens	
<input type="checkbox"/> Food _____	<input type="checkbox"/> Molds	

- List any environmental control measures, pre-medications, and/or dietary restrictions that your child needs to prevent an asthma episode:

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- Peak Flow Monitoring:

Personal Best Peak Flow Number: \_\_\_\_\_

Monitoring Times: \_\_\_\_\_

- Daily Medication Plan (taken at home):

**GREEN ZONE- No asthma symptoms, able to do all activities, or medication to prevent exercise induced asthma**

Name

Dosage

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

**YELLOW ZONE: asthma symptoms-cough, wheeze, short of breath, limited activities**

Emergency action is necessary when your child has the following symptoms: \_\_\_\_\_

\_\_\_\_\_.

Emergency action is necessary when your child has a peak flow reading of: \_\_\_\_\_.

● **Steps to take during an asthma episode:**

1. Give rescue medications listed below
2. Have child return to classroom if \_\_\_\_\_
3. Contact parent if \_\_\_\_\_
4. Seek emergency medical care (CALL 911) if the student has any of the following:

**RED ZONE:**

- **No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached.**
- **Peak flow of \_\_\_\_\_**
- **Fast or Hard time breathing with:**
  - **Chest and neck pulled in with breathing**
  - **Child is hunched over**
  - **Child is struggling to breathe**
- **Trouble walking or talking**
- **Stops playing and can't start activity again**
- **Lips or fingernails are gray or blue**

● **Emergency Asthma Medications to be Taken at School (requires medication authorization on file):**

Name	Dosage	Exp. Date	When to Use
1.			
2.			
3.			
4.			

<b>Dr. Name:</b>	<b>Dr. Phone #:</b>
<b>Dr. Signature:</b>	<b>Date:</b>

**Has the child been instructed in:**

\_\_\_\_\_ Warning signs/symptoms of asthma attack? \_\_\_\_\_ Use of inhaler \_\_\_\_\_ Use of Peak Flow Meter?

\_\_\_\_\_ Parent Signature \_\_\_\_\_ Date

