Newburg R-II School District

Phone: (573)762-9653 Fax: (573)762-2498

Asthma Action Plan for Home & School

Name: _____ DOB: ____/____/_____

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

☐ He/she has had many or severe asthma attacks/exacerbations

😀 GREEN ZONE Have the child take these medicines every day, even when the child feels well.

Always use a spacer (IF PROVIDED) with inhalers as directed.

Controller Medicine(s): **GIVE THESE MEDICATIONS AT HOME** _____

Rescue Medicine: Albuterol/Levalbuterol _____ puffs every four hours as needed.

Exercise Medicine: Albuterol/Levalbuterol _____ puffs 15 minutes before activity as needed.

😐 YELLOW ZONE Begin the sick treatment plan if the child has a cough, wheeze, shortness of breath, or tight chest. Have the child take all of these medicines when sick. SEND HOME

Rescue Medicine: Albuterol/Levalbuterol _____ puffs every four hours as needed.

Controller Medicine(s):

- ☐ Continue GREEN ZONE medicines: _____
- ☐ Add: _____
  _____
- ☐ Change: _____

If the child is in the YELLOW ZONE more than 24 hours or is getting worse, follow RED ZONE and call the doctor right away!

😟 RED ZONE If breathing is hard and fast, ribs sticking out, trouble walking, talking, or sleeping. GET HELP NOW!

Take rescue medicine(s) now

Rescue Medicine: Albuterol/Levalbuterol _____ Puffs every _____

Take: _____

_____

If the child is not better right away, call 911

Please call the doctor any time the child is in the red zone.

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Asthma Action Plan for Home & School (continued)

Asthma Triggers: (list)

School Staff: Follow the YELLOW and RED ZONE plans for rescue medicines according to asthma symptoms. Unless otherwise noted, the only controllers to be administered in school are those listed as "given in school" in the GREEN ZONE.

- ☐ **Both the asthma provider and the parent feel that the child may carry and self-administer their inhalers.**
- ☐ **School nurse agrees with the student self-administering the inhalers.**

Asthma Provider Printed Name and Contact Information:	**Asthma Provider Signature:** **Date:**

Parent/Guardian: I give written authorization for the medications listed in the action plan to be administered in school by the nurse or other school members as appropriate. I consent to communication between the prescribing health care provider/clinic, the school nurse, the school medical advisor and school-based health providers necessary for asthma management and administration of this medication.

Parent/Guardian Signature: **Phone:** **Date:**	**School Nurse Reviewed:** **Date:**

**PLEASE SEND A SIGNED COPY BACK TO THE PROVIDER LISTED ABOVE.*