Asthma Action Plan

AUSTIN Independent School District | Health Services and Nursing

Student Name _____ Student ID# _ Date of Birth _____

Emergency contact _____ Phone _____ School _____

TO BE COMPLETED BY A PHYSICIAN

SEVERITY CLASSIFICATIONS

☐ Intermittent ☐ Moderate Persistent
☐ Mild Persistent ☐ Severe Persistent

TRIGGERS

☐ Colds ☐ Animals ☐ Pollen ☐ Other:
☐ Exercise ☐ Weather ☐ Mold
☐ Smoke ☐ Food ☐ Dust

EXERCISE

☐ Pre-medication (how much and when): _____
☐ Exercise modification: _____

GREEN ZONE: DOING WELL

SYMPTOMS:
- Breathing is good
- No cough or wheeze
- Can work and play
- Sleeps well at night

PLAN Takes control medicines

List Medicine(s)	How Much to Take	When to Take It

YELLOW ZONE: GETTING WORSE CONTACT PHYSICIAN IF USING QUICK-RELIEF MEDICINE MORE THAN 2 TIMES A WEEK.

SYMPTOMS:
- Some problems breathing
- Cough, wheeze, or chest tight
- Problems walking or playing
- Waking up at night

PLAN Continue control medicines and add quick-relief medicines.

Medicine	How Much to Take	When to Take It

If your symptoms return to the GREEN ZONE after 1 hour of quick-relief treatment:
- Take quick-relief medicine every 4 hours for one to two days.
- Change your long-term control medicine by: _____
- Contact your physician for follow-up care.

If your symptoms DO NOT return to the GREEN ZONE after 1 hour of quick-relief treatment:
- Take the quick-relief medicine again.
- Change your long-term control medicine by: _____
- Call your physician within _____ hour(s) of modifying your medication routine.

RED ZONE: MEDICAL ALERT FOR AMBULANCE AND EMERGENCY MEDICAL SERVICES, CALL 911.

SYMPTOMS:
- Lots of problems breathing
- Cannot walk or play
- Getting worse instead of better
- Medicine is not helping

PLAN Continue control medicines and add the medicines listed below.

Medicine	How Much to Take	When to Take It

GO TO THE HOSPITAL OR CALL 911 IF
- Still in the RED ZONE after 15 minutes
- You have not been able to reach your doctor

CALL 911 IMMEDIATELY IF THESE DANGER SIGNS ARE PRESENT:
- Trouble walking or talking due to shortness of breath
- Lips or fingernails are blue

PHYSICIAN AUTHORIZATION

Medication Authorization: Please give this student the medication listed above according to my instructions.
Self-Carry and Self-Administration Authorization: This student is capable of carrying and self-administering this medication: **Yes** ◯ **No** ◯

Physician Signature Date Physician's name:
Phone number: _____

PARENT/GUARDIAN AUTHORIZATION

Medication Authorization: I request that school personnel administer medication to my child according to the physician's instructions in this plan.
Self-Administration: I request that my child be allowed to carry & self-administer quick-relief medicine if the physician agrees: **Yes** ◯ **No** ◯

_____ _____
Parent/Guardian Signature Date

Parent:/Guardian's Name _____
Phone number: _____