Wesleyan Christian Academy
ASTHMA ACTION PLAN

STUDENT NAME: ______________________________ **DOB** (day/mo/yr): ____________ Grade__________

Asthma Triggers: (Check those which apply to this student)

___Exercise ___Emotions (when upset) ___cigarette smoke, odors (paint/markers/perfumes)
___Colds (viral illness) ___Irritants: chalk dust, dust ___Pollens (tree, grasses, weeds)
___Weather changes ___Molds ___Animal dander-type:_________
___Cold air changes ___Dust and dust mites ___Other_______________________________

GREEN ZONE — DOING WELL	Take these long-term control medicine each day:
• No cough, wheeze, chest tightness • Can work and play • If uses peak flow meter, peak flow 80-100% of personal best Personal best _________	**Medicine** / **How much to take** / **When to take it** _______ _______ _______ _______ _______ _______ _______ _______ _______ _______ _______ _______
Before Exercise	☐ ______________ ☐ _____ puffs, 5-15 minutes before exercise ☐ Uses spacer or chamber ☐ Uses nebulizer
YELLOW ZONE — GETTING WORSE	**Add quick relief medicine:**
• Cough, wheeze, chest tightness • Some problems breathing • Wakes at night **OR** • Peak flow 50-80% of personal best	☐ Take ________________ ☐ _____ puffs ☐ Uses spacer or chamber ☐ Uses nebulizer ☐ May repeat every 20 minutes up to one hour • **If symptoms return to GREEN ZONE after 1 hour of above treatment continue monitoring to stay in the green zone.** • **If symptoms do NOT return to GREEN ZONE after 1 hour of above treatment contact parent.** • **If not improving or getting worse, follow RED ZONE actions.**
RED ZONE — MEDICAL ALERT	☐ Take ________________ ☐ _____ puffs ☐ Uses spacer or chamber ☐ Uses nebulizer ☐ May repeat every 20 minutes up to one hour ☐ Take ______________mg ______times a day for _____days
• Medicine is not helping • Problems breathing • Cannot work or play **OR** • Peak flow less than 50% of personal best	**Take to hospital or call 911 for severe symptoms :** • Still in RED ZONE after 15 minutes • Lips or fingernails are blue • Difficulty talking or walking • Ribs show with breathes

Note: Peak flow will only be assessed when a peak flow meter is provided by the student.

SELF ADMINISTRATION: ☐ Student is capable to safely and properly self-administer inhaler medication(s).

Emergency Contacts:

Parent/Guardian: ____________________ Phone #1: _____________ Phone #2: _____________

Parent/Guardian: ____________________ Phone #1: _____________ Phone #2: _____________

Alternate contact if parent cannot be reached:

Name/Relationship: __________________ Phone #1: _____________ Phone #2: _____________

Physician: ____________________ Address: ______________________ Phone: _____________

I authorize school personnel to administer medications as described and directed above.

Physician Signature ______________________ Date __________

Parent signature _________________________Date __________

3/2017