KENSTON SCHOOLS

ASTHMA HEALTH CARE ACTION PLAN

TO BE COMPLETED BY PARENT:

Student's Name: _____ Date of Birth:_____ Grade: _____

Parent/Guardian:_____ Phone Number:_____ Cell: _____

Emergency Contact: _____ Relationship:_____ Phone: _____

Name of Healthcare Provider:_____ Phone: _____ Fax:_____

What triggers your child's asthma attack? (Check/Describe all that apply)

___ Illness ____ Cigarette or other smoke Food _____
___ Emotions ____ Exercise/Physical activity Allergies _____
___ Weather Changes ____ Chemical Odors Other_____

Describe the symptoms your child experiences before or during an asthma episode (Check all that apply)

___ Cough ____ Tightness on chest ____ Shortness of Breath ____ Wheezing
___ Runny nose ____ Feeling tired/weak Other _____

TO BE COMPLETED BY HEALTH CARE PROVIDER:

This child's asthma is: _____ Intermittent _____ Mild/Moderate Persistent _____ Severe Persistent
_____ Exercise-induced

SYMPTOMS (Please describe additional) **TREATMENT** (Please describe for each zone)

WELL – GREEN ZONE

- Usual medications
- No cough or wheeze
- Sleeps through night
- No rescue meds needed
- No activity restriction

SICK – YELLOW ZONE

- Needs reliever medication more often
- Increased asthma symptoms
- Wakes at night due to asthma
- Unable to do usual activities

EMERGENCY – RED ZONE

- Reliever medications do not help
- Very short of breath
- Constant cough

If treatment not working well, call parent and/or 911.

Call 911 immediately if:

Child is struggling to breathe after taking Albuterol
Child has trouble walking or talking
Child has lips or fingernails that are gray or blue
Child's chest or neck is pulling with breathing

PATIENT/STUDENT INSTRUCTIONS:

_____ Student has been instructed in the proper use of all his/her medications, and in my opinion, the student may carry and use his/her inhaler.
_____ Student is to notify the nurse after using inhaler.
_____ Student needs supervision or assistance to use his/her inhaler.
_____ Student should **NOT** be able to carry his/her inhaler at school.

_____ _____ _____
Health Care Provider Signature Printed Name of Provider Date

_____ _____
Parent Signature Date