ASTHMA ACTION PLAN SCHOOL YEAR 20___-20___

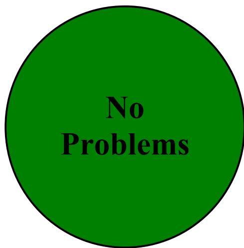
Name____________________________ DOB______________
Parent/Guardian____________________ Ph_____________
Doctor____________________________ Ph______________

Category of Severity: ☐ **Mild** ☐ **Moderate** ☐ **Severe**

Peak Flow Rate

☐ Check peak flow daily in the morning before school.
☐ Check peak flow with breathing trouble.

Rescue medication given according to peak flow:



GO: **(>80% of best PF) PEAK FLOW IS GREATER THAN__________________**
NOTE: No rescue med needed. Use the controller medicine EVERY DAY even if the peak flow is in the green zone.

CAUTION: **Peak flow is ______ to ______ (50-80% of best PF)**
Take rescue medicine: _____ Puffs/Neb of the rescue medicine. Recheck your peak flow in 15 min. May repeat___ times.
NOTE: Parent should contact the doctor if child needs rescue med. > 2 times/wk to see if medication change is necessary.

DANGER: **Peak flow is lower than ________ (<50% of best PF)**
Use your rescue medicine: ______ Puffs/Neb of ________
Recheck your peak flow in 15 min.
If still in red zone, use another _____ Puffs/Neb and
CALL PARENT/DOCTOR FOR FURTHER INSTRUCTIONS.
NOTE: Call 911 if child is in severe distress.

PERSONAL BEST PF

____

CONTROLLER MEDICINES
KEEP AT HOME. TAKE DAILY.

____
____
____
____

RESCUE MEDICINE

____

☐ **USE RESCUE INHALER ______ PUFFS BEFORE EXERCISE/GYM/SPORTS**

☐ **PRN AS NEEDED**

I hereby release the local School Board and their agents and employees from any liability that may result from my child taking the prescribed medication. I give permission for this student to receive medications and for healthcare providers to exchange information regarding the care of my child.

☐ I have instructed the student in the proper use of his/her rescue medication, and the student is able to perform procedure alone and may carry their inhaler with them.

I agree to provide an extra rescue medication inhaler to be kept in school for emergency.

Physician signature: ____________________________ Date___________ Parent/Guardian: _______________________Date:____________

Dare County Asthma Coalition