Lee County School District
Asthma Action Plan

Student's Name _____ Student's DOB _____

Emergency Contact _____ Phone number _____

Physician/Health Care Provider _____ Phone number _____

Severity Classification

☐ Mild Intermittent ☐ Moderate Persistent

☐ Mild Persistent ☐ Severe Persistent

Triggers

☐ Colds ☐ Dust ☐ Weather

☐ Exercise ☐ Smoke ☐ Air Pollution

☐ Animals ☐ Food

☐ Other _____

Control Medications (Home medications)

Green Zone: Doing Well

Symptoms *Breathing is good *No cough or wheeze *Can work and play *Sleeps all night

Medication	Puffs	Minutes prior to exercise

☐ with aerochamber/spacer

Yellow Zone: Getting Worse

Symptoms * Some difficulty breathing * Cough, wheeze or chest tight * Problems working or playing * Awake at night

Medication	Puffs	Frequency

☐ with aerochamber/spacer

☐ May repeat every _____ minutes _____ times if symptoms not improved. Notify parent/guardian and school nurse.

Nebulizer order	Dose	Frequency

All equipment needed to perform nebulizer treatment will be provided and maintained in good working order by parent/guardian . School personnel will assume no responsibility for the maintenance or delivery of the necessary equipment. Nebulizer treatment/procedure may be administered by unlicensed personnel trained by the school nurse.

Red Zone: Medical Alert

Symptoms Much difficulty breathing *Cannot work or play *Getting worse instead of better *Medicine is not helping

Call an ambulance immediately if the following danger signs are present

*Still in the red zone after 15 minutes *Trouble walking/talking due to shortness of breath *Lips or fingernails are blue

☐ If pulse oximeter is available, call 911 if O2 saturation less than _____

Authorization to Carry and Self-Administer Medication - Must be completed by Health Care Provider

Student may carry and self-administer rescue inhaler ◯ Yes ◯ No If yes, must complete the following:

☐ Student instructed on and verbalized understanding of the name, purpose, dose of medication.

☐ Student instructed on disease process of asthma and verbalized understanding of when to take medication.

☐ Student instructed on and verbalized understanding of his/her responsibility in carrying medication(s) and agrees not to share

☐ Student demonstrated correct use/administration of medication.

I, the student, understand that I am responsible and accountable for using and carrying the above medication as prescribed. I also understand that if there is irresponsible behavior or a safety risk the privilege of carrying the above medication will be rescinded.

Student's Signature _____ Date _____

Physician's Signature _____ Date _____

Parent's Signature _____ Date

Nurse Signature _____ Date _____