Asthma Action Plan For School

(To Be Completed By Health Care Provider and Parent)

Student Name: _____ Date of Birth: _____

Grade: _____ School Year: _____ Homeroom Teacher: _____

Asthma Triggers: _____

Daily Medications: _____

1. Safe Zone:	**1. Action:**
Child has any of these: • Breathing is good. • No cough or wheeze • Can work/play Peak flow in this area most of the time is: _____ to _____.	❑ Avoid asthma triggers. ❑ Use _____medication 20 minutes prior to exercise.

2. Caution Zone:	**2. Action:**
Child has any of these: • Cough • Wheeze • "Tight" Chest • Difficulty with work/play Peak flow in this area most of the time is: _____ to _____.	❑ Use _____medication. ❑ Limit activity. ❑ Call parent if quick relief medicine is used more than _____ times in one week. ❑ Call doctor if quick relief medicine is used more than _____times in one week.

3. Danger Zone:	**3. Action:**
Child has any of these: • Medicine not helping. • Breathing hard & fast. • Nostrils flaring. • Can't walk or talk well. • Ribs showing. Peak flow in this area most of the time is: _____ to _____.	❑ Use _____medication. ❑ Notify parent. ❑ Notify doctor. ❑ Call 911. ❑ Perform CPR if necessary.

HealthCare Provider: _____ Phone#_____
(Please Print) Fax#_____
Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date:_____

Home Phone#_____ Work Phone#_____ Cell Phone#_____