GARLAND ISD
ASTHMA ACTION PLAN

(To be completed each school year and kept on file with the school nurse)

Student's Name:_____ Grade:_____ DOB:_____

Teacher's Name:_____ School Year:_____

Parent/Guardian

Name(s) _____ Home phone: _____

Address: _____ Work phone: _____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Physician student sees for asthma: _____ Phone: _____

Other physician: _____ Phone: _____

MANAGEMENT PLAN

Routine Use **_____ Peak Flow Green Zone 80-100%**

Medication	Purpose	Directions	Times

Breakthrough Symptoms (Specify) _____
_____Peak Flow Yellow Zone 50-80%

Medication	Purpose	Directions	Times

Further Intervention **_____ Peak Flow Red Zone less than 50%**

Medication	Purpose	Directions	Times

Alert: If symptoms not relieved and peak flow improvement not obtained within_____, notify parent and doctor or go to the nearest emergency room

* EMERGENCY PLAN *

Emergency action is necessary when this student exhibits the following symptoms:

1. ______________________________ 3. ______________________________

2. ______________________________ 4. ______________________________

Steps to take during an asthma episode:

1. Give emergency medications:

   A. Bronchodilator (Quick-relief medication):

   Name: ____

   Purpose: ____

   Dosage: ________________________ When to use: ____________________________

   Can be repeated for severe breathing difficulty __________times ________minutes apart.

   Call 911 or EMS if minimal or no improvement.

   B. Other medications:

   Name: ____

   Purpose: ____

   Dosage: ________________________ When to use: ____________________________

   Additional instructions: ______________________________________

These medications are prescribed for the time period ______________ until ____________

2. Seek emergency medical care if this student experiences any of the following:

- No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached
- Student exhibits:

○ Chest and neck pulled in with breathing

○ Hunched over while breathing

○ Struggling to breathe

○ Trouble walking or talking

○ Stops playing and cannot start activity again

○ Lips of fingernails turn gray or blue

Comments and special instructions: ____

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____ ______________

Physician's Signature *Date*

I give permission to my child's school to administer daily and emergency medications as necessary, in accordance with physician's instructions above.

____ ______________

Parent/Guardian's Signature *Date*