

Attn: School Nurse  
P.O. Box 3129  
Montrose, MI 48457



# Montrose Community Schools

810-591-8880  
810-591-8870  
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Preparing our community for life long learning

## Asthma Action Plan

StudentName _____	Date of Birth _____
School/ Grade _____	Teacher _____
Parent / Guardian _____	
Address _____	
Home Phone _____	Work _____ Cell _____
<b>Alternate contacts if parent cannot be reached:</b>	
Name _____	Relationship: _____
Phone _____	Cell _____
Name _____	Relationship: _____
Phone _____	Cell _____

### Describe asthma symptoms: (check each that applies to student)

Cough \_\_\_\_\_ Wheezes \_\_\_\_\_  
Red Face \_\_\_\_\_ Pulling in of skin around neck muscles, collarbone, ribs, under breast bone \_\_\_\_\_  
Sits Down \_\_\_\_\_ Shortness of breath \_\_\_\_\_  
Holds Chest \_\_\_\_\_ Other \_\_\_\_\_

### Triggers:

Exercise \_\_\_\_\_ Cold weather changes \_\_\_\_\_ Irritants (dust, smoke, perfume, paint, markers, ect) \_\_\_\_\_  
Emotions \_\_\_\_\_ Pollens (trees, grasses, weeds) \_\_\_\_\_ Please specify: \_\_\_\_\_  
Molds \_\_\_\_\_ Illness / respiratory infections \_\_\_\_\_ Other \_\_\_\_\_

How often does your child have an asthma attack? Week \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_

**Peak flow meter:** Yes \_\_\_ No \_\_\_ **Spacer:** Yes \_\_\_ No \_\_\_  
Monitoring peak flow times \_\_\_\_\_

### What usually helps if an asthma attack occurs? (Ex., sit leaning forward, loosen clothing, reassurance, ect.)

\_\_\_\_\_  
\_\_\_\_\_

### Daily Routine Asthma Medications

Medication Name	Dose	Instructions
1. _____		
2. _____		
3. _____		
4. _____		

Side effects of medications \_\_\_\_\_  
\_\_\_\_\_

I have provided all information that may be helpful in treating my child's asthma condition. I understand and agree with the use of the above Asthma Action Plan. I will notify the school should any health status or medication changes occur. I give my permission for this plan to be available to school personnel as needed. The above named student has been instructed on proper use of his/her inhaler with the physician, and is responsible for using this medication at his/her discretion. Irresponsible or inappropriate use of the inhaler and/or failure to follow the Asthma Action Plan by the student will require a reassessment of the permission to self carry and self medicate.

**Parent / Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



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## Asthma Action Plan

<p><b><u>Green Zone &gt;&gt;&gt;&gt;&gt;&gt;&gt;&gt;</u></b></p> <ul style="list-style-type: none"> <li>• Breathing is good / no difficulty</li> <li>• No cough or wheeze</li> <li>• Tolerating activity easily</li> </ul> <p>Peak flow above: _____</p> <p>* Indicates that student's asthma is under good control.</p>	<p><b>Treatment Plan</b></p> <p>School medication(s): _____</p> <p>Dose: _____</p> <p>Instructions: _____</p> <p>Use before exercise / physical activity: Yes _____ No _____</p> <p>Other: _____</p>
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<p><b><u>Yellow Zone &gt;&gt;&gt;&gt;&gt;&gt;&gt;&gt;</u></b></p> <ul style="list-style-type: none"> <li>• First sign of cold</li> <li>• Exposure to known trigger</li> <li>• Cough</li> <li>• Mild Wheeze</li> <li>• Tight chest</li> <li>• Coughing at night</li> <li>• Other _____</li> </ul> <p>Peak flow between _____ and _____</p> <p>* Indicates a warning that student's asthma may flare unless additional measures are taken</p>	<p><b>Treatment Plan</b></p> <p>Reliever medication: _____</p> <p>Dose: _____</p> <p>Instructions: _____</p> <p>Reliever medication: _____</p> <p>Dose: _____</p> <p>Instructions: _____</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Recheck peak flow _____ minutes after treatment (if applicable)</li> <li><input type="checkbox"/> May return to class if symptoms or peak flow improve.</li> <li><input type="checkbox"/> Vigorous activity should be avoided.</li> <li><input type="checkbox"/> Call parent to inform of situation</li> <li><input type="checkbox"/> If student is not improving or getting worse, follow danger zone treatment.</li> </ul>
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<p><b><u>Danger Zone &gt;&gt;&gt;&gt;&gt;&gt;&gt;&gt;</u></b></p> <ul style="list-style-type: none"> <li>• No improvement 15-20 minutes after <i>initial</i> medication treatment.</li> <li>• Breathing hard and fast</li> <li>• Nose opens wide</li> <li>• Chest, neck, rib muscles pulled in when breathing</li> <li>• Lips and /or fingernails blue</li> <li>• Trouble talking and walking</li> <li>• Becoming lethargic</li> <li>• Peak flows do not respond to medication.</li> </ul> <p>Peak flow below: _____</p> <p><b>*This is a medical emergency.</b></p>	<p><b>Treatment Plan</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <b>Call parent</b> to inform of urgent situation.</li> <li><input type="checkbox"/> If symptoms continue to be severe and / or parents are unavailable,</li> </ul> <p style="text-align: center;"><b>CALL 911 IMMEDIATELY.</b></p> <p>Emergency Medication: _____</p> <p>Dose: _____</p> <p>Instructions: _____</p> <p>Other: _____</p>
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<p><b>Physician Signature:</b> _____</p> <p>Physician Name: _____</p> <p>Phone: _____</p> <p>Fax: _____</p>	<p>Date: _____</p> <p>Special Instructions: _____</p> <p>_____</p> <p>_____</p>
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