Please return to: School_____
Fax _____

AMERICAN LUNG ASSOCIATION® of Arizona

Parent Form: Asthma Action Plan

Academic year: _____

School: _____

Name of School Nurse: _____

School Nurse Phone: (520) _____ Fax: (520) _____

Name of Student: _____ Age: _____ Date of Birth: _____

Teacher: _____ Grade: _____ Room: _____

Asthma Care Physician _____ Phone Number _____

Other Physician _____ Phone Number _____

When my child is nearing an asthma episode, I notice the following signs (please check all that apply):

☐ Runny/Stuffy Nose ☐ Funny Feeling in Chest ☐ Itchy Throat ☐ Itchy Chest ☐ Tummy Ache

☐ Feeling Weak ☐ Headache ☐ Dry Mouth ☐ Getting Upset ☐ Nervous

☐ Sad ☐ Sneezing ☐ Coughing ☐ Watery Eyes ☐ Circle Under Eyes

☐ Other (please list):

My child's asthma triggers (things that start an asthma attack) are (please check all that apply):

☐ Animals With Fur ☐ Dust ☐ Cigarette Smoke ☐ Strong Smells

☐ Cold Air ☐ Humid Air ☐ Colds ☐ Sinus Infections

☐ Exercise (Running, Sports) ☐ Aerosols (Hair Spray, Perfume) ☐ Emotions (Sad, Happy)

☐ Cockroaches ☐ Mold

☐ Food (please list): _____

☐ Other (please list): _____

I have reviewed my child's action plan with the school nurse and believe all of the information to be accurate. I agree to notify the school nurse of any changes in my child's condition including emergency room visits and hospitalizations. I give the school nurse and my child's physician permission to contact one another or my insurance/Medicaid carrier for the purpose of obtaining information related to my child's health. A reasonable effort will be made to obtain the information from me prior to any other source.

Parent/Guardian Signature _____ Date _____

Please have your physician complete the Physician Asthma Action Plan.
Return both forms to School Nurse.

Developed by the School Asthma Committee, Tucson, AZ. Permission to copyright given to all schools.
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TUCSON UNIFIED SCHOOL DISTRICT

School Health Services

Physician Form: Asthma Action Plan

Please return to:

School _____
Address, _____
City/State/Zip _____
Nurse: _____
Fax: (520) _____ Phone: (520) _____

Student Name: _____ Physician: _____
DOB: _____

POSSIBLE WARNING SIGNS	PEAK FLOW ZONES	TREATMENT PLAN
▪ sleeping without symptoms ▪ able to do normal activities without symptoms **OR** ▪ peak flow 80 to 100% of predicted or personal best Student's personal best peak flow meter reading is: _____ **OR** Student's predicted peak flow meter reading is: _____ **ALL CLEAR!**	**GREEN ALL CLEAR!** _____ to _____ **Greater than** 80% of Best of Predicted Peak Flow	**Long-term Control** - Daily Medications Medicine How Much Frequency _____ _____ **Before exercise**: Take o 2 or θ 4 puffs of _____ _____ _____ minutes before exercise.
Early warning signs of asthma may be seen: ▪ cold symptoms and/or fever ▪ coughing/wheezing but able to do normal activities ▪ shortness of breath with activity ▪ chest tightness ▪ waking at night with cough/wheeze **OR** ▪ peak flow 50 to 80% of personal best **BE CAREFUL!**	**YELLOW CAUTION!** _____ to _____ 50- 80% of Best of Predicted Peak Flow This is **NOT** where the student should be every day. **TAKE ACTION**	**QUICK RELIEF** - For Mild/Moderate Symptoms First Medicine: _____ o 2 or θ 4 puffs or θ by nebulizer one time Then: If improvement in 15 minutes: _____ _____ If **no** improvement in 15 minutes: _____ _____ _____
This is an emergency, you need help! 1. difficulty walking or talking 2. uses neck/stomach muscles when breathing 3. needs rescue medication more frequently than every 4 hours 4. constant coughing 5. worsening symptoms after treatments 6. blue or gray lips or fingernails **OR** 7. peak flow <50% of personal best **DANGER!**	**RED DANGER!** Below_____ Less than 50% of Best of Predicted Peak Flow	**ALERT** - For Severe Symptoms First, take this medicine: _____ o 2 or θ 4 puffs or θ by nebulizer one time If feeling better or repeat peak flow is in yellow zone, call doctor and ask for further instructions If no improvement **or** repeat peak flow is in red zone **or** nails or lips are blue **or** breathing is difficult: **GO TO THE EMERGENCY ROOM OR CALL 911!!**

Physician Signature_____Date _____