

OPTIMA HEALTH ASTHMA HEALTH CARE ACTION PLAN

TO BE COMPLETED BY PARENT:

Child's Name _____ Date of Birth _____ School _____ Grade _____
 Parent/Caregiver _____ Phone (H) _____ Phone (W) _____ Phone (Cell) _____
 Address _____ City _____ Zip _____
 Emergency Contact _____ Relationship _____ Phone _____
 Name of Physician _____ Office phone number _____

What triggers your child's asthma attack: (Check all that apply)

- Illness Cigarette or other smoke Food _____
 Emotions Exercise Allergies cat dog dust mold pollen
 Weather changes Chemical odors Other _____

Describe the symptoms your child experiences before or during an asthma episode: (Check all that apply)

- Cough "Tightness" in chest Rubbing chin/neck
 Shortness of breath Breathing hard/fast Feeling tired/weak
 Wheezing Runny nose Other _____

TO BE COMPLETED BY PHYSICIAN:

The child's asthma is: mild persistent moderate persistent severe persistent EXERCISE-INDUCED

Symptoms	Peak Flow OR Monitoring	Treatment				
WELL <ul style="list-style-type: none"> • No cough or wheeze • Able to sleep through the night • Able to run and play • Usual medications control asthma 	GREEN ZONE > _____	Controllers				
		<input type="checkbox"/> Advair _____				
		<input type="checkbox"/> Flovent (with spacer) _____				
		<input type="checkbox"/> Pulmicort				
		<input type="checkbox"/> Singulair				
		<input type="checkbox"/> Serevent				
		Relievers				
		<input type="checkbox"/> Albuterol (with spacer/nebulizer)	2 puffs 1 minute apart q4° prn	<input type="checkbox"/> 20 min before exercise		
		<input type="checkbox"/> Other				
SICK <ul style="list-style-type: none"> • Increased asthma symptoms (shortness of breath, cough, chest pain) • Wakes at night due to asthma • Unable to do usual activities • Needs reliever medications more often 	YELLOW ZONE _____ to _____	1. <input type="checkbox"/> Continue daily controller medications 2. Give albuterol 2-4 puffs (one minute between puffs) with spacer or 1 nebulizer treatment, wait 20 min. <input type="checkbox"/> If no improvement, repeat 2-4 puffs. Wait 20 minutes. <input type="checkbox"/> If no improvement, repeat 2-4 puffs. This will be 3 doses in one hour, proceed to 3 3. If child returns to Green Zone: <input type="checkbox"/> Continue to give albuterol 2 puffs every 4 hours for 1 to 2 more days AND <input type="checkbox"/> Increase controller to _____ for next 7 days 4. <input type="checkbox"/> No physical exercise <input type="checkbox"/> Physical exercise as tolerated If child remains in Yellow Zone for more than 1-2 days or requires albuterol more than every 4 hours, call your doctor NOW!				
		EMERGENCY! <ul style="list-style-type: none"> • Very short of breath, difficulty breathing • Constant cough • Reliever medications do not help 			RED ZONE < _____	Give albuterol (2 puffs with spacer) NOW, and repeat every 20 minutes for 2 more doses OR give 1 dose nebulized albuterol – Call your doctor Seek emergency care or call 911 if: <ul style="list-style-type: none"> ▪ Child is struggling to breathe and there is no improvement 20 minutes after taking albuterol ▪ Trouble talking or walking ▪ Lips or fingernails are gray or blue ▪ Chest or neck is pulling in with breathing

For inhaled medications:

- Student is able to perform procedure alone and may carry the inhaler with them, consult school nurse for local protocol Student is able to perform procedure with supervision
 Student requires a staff member to perform procedure

Notify health care provider if:

- More than 2 absences related to asthma per month The child is persistently in the Yellow Zone
 Albuterol is being used as a rescue medication 2 times per week at school

Current school year

Provider Signature

Date

I give my permission for school personnel to follow this plan, administer medication and care to my child and contact my physician if necessary. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring device. I approve this Asthma Management Plan for my child.

Parent Signature

Date