Provider: _____ Clinic: _____

American Lung Association.

My Asthma Action Plan

Name: _____ DOB: ____ / ____ / _____

Severity Classification: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Asthma Triggers (list): _____

Peak Flow Meter Personal Best: _____

Green Zone: Doing Well

Symptoms: Breathing is good – No cough or wheeze – Can work and play – Sleeps well at night
Peak Flow Meter _____ (more than 80% of personal best)

Flu Vaccine—Date received: _____ Next flu vaccine due: _____ COVID19 vaccine—Date received: _____

Control Medicine(s)	Medicine	How much to take	When and how often to take it

Physical Activity ☐ Use Albuterol/Levalbuterol ____ puffs, 15 minutes before activity
☐ with all activity ☐ when you feel you need it

Yellow Zone: Caution

Symptoms: Some problems breathing – Cough, wheeze, or tight chest – Problems working or playing – Wake at night
Peak Flow Meter _____ to _____ (between 50% and 79% of personal best)

Quick-relief Medicine(s) ☐ Albuterol/Levalbuterol ____ puffs, every 20 minutes for up to 4 hours as needed
Control Medicine(s) ☐ Continue Green Zone medicines
☐ Add _____ ☐ Change to _____

You should feel better within 20-60 minutes of the quick-relief treatment. If you are getting worse or are in the Yellow Zone for more than 24 hours, THEN follow the instructions in the RED ZONE and call the doctor right away!

Red Zone: Get Help Now!

Symptoms: Lots of problems breathing – Cannot work or play – Getting worse instead of better – Medicine is not helping
Peak Flow Meter _____ (less than 50% of personal best)

Take Quick-relief Medicine NOW! ☐ Albuterol/Levalbuterol ____ puffs, _____ (how frequently)

Call 911 immediately if the following danger signs are present:
- Trouble walking/talking due to shortness of breath
- Lips or fingernails are blue
- Still in the Red Zone after 15 minutes

Emergency Contact Name _____ Phone (____) _____ - _____

Date: ____ / ____ / _____

BRAZOS ISD ASTHMA RECOMMENDATIONS FOR SELF-ADMINISTRATION

This plan is in accordance with HB 1688, which passed during the 2001 Texas Legislative Session. This bill allows students to self administer asthma medication while at school or school functions with permission from parents and physicians.
(To be completed at the beginning of each school year and kept on file with the school nurse or office of the principal)

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

Parent/Guardian: _____ Phone: _____

Address: _____

Emergency Contact:

_____

Name Relationship Phone

Physician student sees for asthma: _____ Phone: _____

Please list any medications taken daily to manage asthma, including nebulizer treatments.

	Medication Name	Dosage
1.	_____	_____
2.	_____	_____
3.	_____	_____

SELF-ADMINISTRATION OF ASTHMA MEDICATION

☐ I have instructed _____ (student's name) in the proper way to use his/her medication. It is my professional opinion that he/she should be allowed to carry and self-administer the following medication while on school property or at school related events.

☐ It is my professional opinion that _____ (student's name) should NOT be allowed to carry and self-administer any of the following medications while on school property or at school related events.

A. Bronchodilator (quick relief medication):

Medication: _____

Dosage: _____

When to use: _____

Can be repeated for severe breathing difficulty _____ times and _____ minutes apart.

Call 911 or EMS if minimal or no improvement.

B. Other medication:

Medication: _____

Dosage: _____

When to use: _____

Additional instructions: _____

These medications are prescribed for the time period _____ until _____

Physician's Signature: _____ Date: _____

I agree with the recommendation of my child's physician as noted and have informed my child that he/she may or may not carry his/her asthma medications while on school property or at school related events.

Parent/Guardian Signature: _____ Date: _____