Chicago Public Schools

Asthma Action Plan

Student's Name_____ **Grade**_____ **DOB**_____ **School** _____
Student ID_____ **Inhaler Kept In:**_____ ☐ **Self-Carry**

Action Control Plan

Level of Severity: ☐ Intermittent ☐ Mild Intermittent ☐ Moderate ☐ Persistent ☐ Severe Persistent
Control ☐ Well Controlled ☐ Not Well Controlled ☐ Very Poorly Controlled
Triggers ☐ Animals ☐ Pollen ☐ Dust Mites ☐ Respiratory Infections ☐ Mold ☐ Exercise ☐ Weather ☐ Smoke ☐ Other:_____
Allergies: _____

GREEN ZONE — DOING WELL

- Breathing is normal
- No cough, wheeze, chest tightness, or shortness of breath during the day or night
- Can do usual activities

And, if a peak flow meter is used,
Peak flow: more than_____
(80 percent or more of best peak flow)

Take these long-term control medicines each day.

Controller Medications	How much to take	When to take it	At School
_____	_____	_____	❑ Yes ❑ No
_____	_____	_____	❑ Yes ❑ No
❑ **Rescue** Medications	❑ 2 or ❑ 4 puffs ❑ 6 puffs	❑ 10 – 20 minutes before exercise	❑ Yes ❑ No
_____	❑ PRN_____hrs	_____	

YELLOW ZONE — ASTHMA IS GETTING WORSE

- Cough, wheeze, chest tightness, or shortness of breath, or
- Waking at night due to asthma, or
- Can do some, but not all, usual activities

-Or-
If pulse Oximeter is used 02 Sat
_____% to_____%

First **Add: rescue medicine**
_____ ❑ 2 or ❑ 4 ❑ 6 puffs, every _____ Minutes Repeat every _____Minutes for up to 1 hour
(short-acting beta2-agonist) ❑ Nebulizer solution_____Repeat every_____Minutes

Second **If symptoms (and peak flow, if used) return to GREEN ZONE after 1 hour of above treatment:**
❑Continue monitoring to be sure student stays in the GREEN ZONE
-Or-
If symptoms (and or pulse Ox, if used) do not return to GREEN ZONE after 1 hour of above treatment move to RED ZONE.

RED ZONE — MEDICAL ALERT! DANGER

- Very short of breath, or
- Rescue medicines have not helped,
- Cannot do usual activities, or
- Symptoms are same or get worse after treatment in Yellow Zone Pulse Oximeter < 93%

First **Rescue medicine**
❑_____ ❑ 4 or ❑ 6 puffs every _____Minutes or Nebulizer Solution every_____Minutes
(short-acting beta2-agonist) ☐ 8 puffs

Second **Call 911 if unable to return action to yellow zone after 15 minutes or less, call 911, and parent/guardian.**

LOOK HERE!

Self Administration ❑ By checking this box and signing below, health care provider and parent, give written authorization of permission for this student to self carry and self administer prescription asthma medication during school or at school related events. This includes authorization to coach and discuss this condition and elements of care with health care provider indicated on this form

Date_____Provider Signature_____Provider Printed Name_____Provider Phone_____ Fax _____

Parent/Guardian: I give written authorization for the medications listed in the action plan to be administered in school by the nurse or other school members as appropriate.
I consent to communication between the prescribing health care provider/clinic, the school nurse, the school medical advisor, and for asthma management and administration of this medication.

Date_____ Parent/guardian signature _____ Home phone/cell _____Work_____ Alternate contact number _____

Nurse Signature:_____Nurse Name:_____Office Phone:_____Fax:_____

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