GENESIS
INNOVATION ACADEMY

Student Health Services
Asthma Action Plan

Scholar Name: _____ HR Teacher: _____ DOB: _____

Severity Classification	Triggers		Exercise
___Mild Intermittent ___Mild Persistent ___Moderate Persistent ___Severe Persistent	___Colds ___Exercise ___Animals ___Smoke ___Dust	___Food ___Weather ___Air pollution Other_____	1. Pre-medication (how much and when)_____ 2. Exercise modifications _____ _____

Green Zone: Doing Well **Peak Flow Meter Personal Best = _____.**

Symptoms	Control Medication		
-Breathing is good -No cough or wheeze -Can work and play -Sleeps all night	Medicine _____ _____ _____	How much to take _____ _____ _____	When to take it _____ _____ _____

Peak Flow Meter

More than 80% of personal best or _____

Yellow Zone: Getting Worse **Contact Physician if using quick relief more than 2 times per week.**

Symptoms	Control Medication		
-Some problems breathing -Cough, wheeze or chest tight -Problems working or playing -Wake at night	Medicine _____ _____ _____	How much to take _____ _____ _____	When to take it _____ _____ _____

Peak Glow Meter

Between 50 to 80% of personal best or _____ or _____

IF your symptoms (and peak flow, if used) return to Green Zone after on hour of the quick relief treatment, THEN	IF your symptoms (and peak flow, if used) DO NOT return to Green Zone after 1 hour of the quick relief treatment, THEN
-Take quick-relief medication every 4 hours for 1 to 2 days -Change your long-term control medicines by _____ -Contact your physician for follow-up care	-Take quick-relief treatment again -Change our long-term control medicines by _____ -Call your physician/Health Care Provider within _____ hours of modifying your medication routine

Red Zone: Medical Alert **Ambulance/Emergency Phone Number: _____.**

Symptoms	Continue control medicines and add:		
-Lots of problems breathing -Cannot work or play -Getting worse instead of better -Medicine is not helping	Medicine _____ _____ _____	How much to take _____ _____ _____	When to take it _____ _____ _____

Peak Glow Meter

Between 0 to 50% of personal best or _____ or _____

Activate EMS (call 911) IF the Scolar has ANY of the following symptoms:

- Lips or fingernails are blue or gray
- The scholar is too short of breath to walk, talk, or eat normal
- Coughs constantly
- The scholar gets no relief within 10-15 minutes of quick relief medications OR the scholar has any of the following signs:
  - Persistent chest and neck pulling in with breathing ○ Scholar is hunching over ○ Scholar is struggling to breathe

Comments / Special Instructions: _____

_____

I am the parent/guardian of _ _____ and request that the Asthma Health Care Plan be utilized during school hours.

School employees will not assume any liability for supervising or assisting in the utilization of this health care plan. Completion of this Asthma Health Care Plan authorizes Scholar Health Services to discuss the health care plan with the

appropriate school staff and prescribing health care provider via email, fax, verbal, or written communication with the purpose of providing a safe environment for your child.

Physician/Health Care Provider Signature _____Date: _____

Physician Name (print) _____Phone # _____

Physician Address _____Fax _____

Parent Signature _____ Date: _____

Parent Name (Print) _____ Phone # _____

Received by _____ Date: _____

School Clinic Assistant Signature: _____ Date: _____