SEGUIN INDEPENDENT SCHOOL DISTRICT
SCHOOL HEALTH SERVICES

EMERGENCY HEALTH CARE PLAN

Asthma Action Plan

Student:_____ Grade:_____ DOB: _____

Severity of reaction(s): _____

Mother:_____ Home #:_____ Work #_____ Cell #: _____

Father:_____ Home #:_____ Work #_____ Cell #: _____

Emergency Contact:_____ Relationship:_____ Phone:_____

➔I give consent to follow the plan of action as directed below by my child's physician.

Parent/Guardian Signature: _____ Date:_____

BELOW TO BE COMPLETED BY PHYSICIAN ONLY

GREEN ZONE	**PREVENTATIVE PLAN**	You are doing well with no cough, wheeze or shortness of breath day or night. Use controller medicines daily at home. May use Albuterol or Xopenex 1 or 2 puffs before exercise as needed.
YELLOW ZONE	**RESCUE PLAN**	Symptoms begin: cough, wheezing, shortness of breath, chest tightness, breathing fast or heavy, waking at night with cough, or exercise limitation. Continue controller medicines daily at home.
		Give: (Reliever Medication) • Albuterol or Xopenex by inhaler 1 or 2 puffs four times daily as needed **OR** • _____ by inhaler _____ or _____ puffs _____ daily as needed • Albuterol or Xopenex by nebulizer 1 unit dose vial every 4 hours as needed **OR** • _____ by nebulizer _____ or _____ vial _____ daily as needed
		If no improvement, call the emergency contacts listed above.
RED ZONE	**EMERGENCY PLAN**	You are very short of breath with difficulty walking or talking. Cough or wheeze is constant. Neck or stomach muscles are used to breathe. Reliever medications are not helping.
		Give: • A second dose of reliever medication in 20 minutes **OR** • A second dose of reliever medication in _____ minutes. • **AND** notify parent/guardian. Have parent/guardian pick up student.
		If you cannot say a full sentence in one breath or if you are struggling to breathe, call **911** or go to the nearest hospital emergency room!
ON AIR QUALITY ALERT DAYS		_____ No outdoor exercise _____ Limited outdoor activity (no sprints / running) _____ Exercise as tolerated _____ Unrestricted

ATTENTION PHYSICIAN	It is my professional opinion the above student be allowed to carry and self-administer his/her inhaler while on school property and/or school related events. Inhalers without orders to carry and self administered are kept locked in the school clinic.	**PLEASE CIRCLE** ☞ **SHOULD / SHOULD NOT** Physician's Initials:_____

Doctor's Signature: _____ Date: _____

Doctor's Printed Name: _____

Revised 05-18-15