RCS Asthma Action Plan

AMERICAN LUNG ASSOCIATION.

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)

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

Physical Activity ☐ Use albuterol/levalbuterol _____ puffs, 15minutes before activity

☐ with all activity ☐ when you feel you need it

Yellow Zone: Caution

Symptoms: Some problems — Cough, wheeze, or chest tight — 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 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

PARENT AUTHORIZATION AND SIGNATURE:

I authorize Rockford Christian School and its employees, on my behalf and stead, to administer or attempt to administer (or to allow my child to self-administer while under the supervision of the employees and agents of this school) to my child this lawfully prescribed medication and any prescribed changes. I acknowledge that it be necessary for the administration of medications to my child to be performed by an individual other than a school nurse and specifically consent to such practices. I further acknowledge and agree that when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against the school, its employees and agents arising out of the administration of said medication. In addition, I agree to release, hold harmless, and indemnify Rockford Christian School and its employees from any and all claims, damages, causes of action or injury incurred or resulting from the administration or attempts at administration of said medication. I allow the school nurse to discuss this medication and its effects on my child with the prescribing physician or his representatives. Rockford Christian School, and its employees and agents are to incur no liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of medication by the pupil, regardless of whether authorization was given by the physician, physician's assistant or advanced practice registered nurse.

Emergency Contact _____ Phone (_____) _____- _____

Parent Signature _____ Phone (_____) _____ - _____

Healthcare Provider Signature _____

Print Healthcare Provider Name_____ Address _____

Date _____