**The Brook Hill School Health Manual**
**Individualized Health Care Plan**
**Asthma Action Plan**

**Student Name:** ___________________________________

**Physician Name:**___________________________ **Phone:** ___________________

## Emergency Plan

**Emergency action is necessary when the student has symptoms such as:**

- Tightness in chest
- Cannot do usual activities
- Increase in breathing rate
- Excessive/increased cough
- Chest/Neck pull in with breathing
- Wheezing

| Step 1: If student has any of the above listed symptoms, ***give medications as listed below***. Follow instructions below. | | |
|---|---|---|
| **GREEN ZONE**<br>**Good Response**<br><br>***Breathing rate normal**<br>***Skin color pink**<br>***Alert and active**<br>***No chest tightness**<br>***No cough** | **YELLOW ZONE**<br>**Fair Response**<br><br>***Breathing rate normal or increasing**<br>***Mild difficulty breathing**<br>***Skin color pink**<br>***Mild cough**<br>***Mild chest tightness** | **RED ZONE**<br>**Poor Response**<br><br>***Breathing rate fast**<br>***Severe Breathlessness**<br>***Skin pulling between ribs with each breath**<br>***Nasal flaring**<br>***Continual cough** |
| ⇩ | ⇩ | ⇩ |
| **Return to Normal Routine** | **Call Parent and continue to observe.** | **Get Emergency Treatment!** |

## Emergency Asthma Medications

| | Name | Amount | When to Use |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |

## Asthma Management Plan

- **Identify the things which start an asthma episode (Check each that applies to student.)**

  - ☐ Exercise
  - ☐ Respiratory infections
  - ☐ Change in temperature
  - ☐ Animals
  - ☐ Food___________________
  - ☐ Strong odors or fumes
  - ☐ Chalk dust/ dust
  - ☐ Carpets in the room
  - ☐ Pollens
  - ☐ Molds
  - ☐ Other___________________

Comments:

_______________________________________________________________________________

What helps your child other than medication if an asthma episode occurs?

_______________________________________________________________________________

_______________________________________________________________________________

- **Control of School Environment**

(List any pre-medications, and/or dietary restrictions that the student needs to prevent an asthma episode.)

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

The Brook Hill School
Christ-Centered. College Prep.

**Daily Medication Plan (any medications in addition to Asthma medications)**

| | Name | Amount | When to use |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |

**Comments/Special Instructions:**

**FOR INHALED MEDICATIONS-MUST BE COMPLETED BY PHYSICIAN and PARENT**

I have instructed this student in the proper way to use his/her inhaler. It is my professional opinion that he/she should be allowed to self-administer the inhaler by him/herself in the School Nurse's Office.

____________________________________________________

Physician Signature or Stamp Date

____________________________________________________

Parent/Guardian Signature Phone number Date