Student Asthma Action Plan

The school will use the information provided on this form to develop an individual Asthma Action Plan for your student.

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AMERICAN RESPIRATORY ALLIANCE of WESTERN PENNSYLVANIA

We're All About Breathing®

800-220-1990

www.healthylungs.org

Cranberry Professional Park
201 Smith Drive, Suite E
Cranberry Twp., PA 16066

SCHOOL ASTHMA INITIATIVE SAI

A Program of the American Respiratory Alliance of Western Pennsylvania

DATE **SCHOOL**

❑ Male ❑ Female

STUDENT'S NAME **BIRTH DATE** **GRADE**

ADDRESS

CITY **STATE** **ZIP**

PARENT / GUARDIAN **HOME PHONE** **WORK PHONE**

EMERGENCY CONTACT **RELATIONSHIP** **PHONE**

STUDENT'S PRIMARY DOCTOR **PHONE** **DATE OF LAST VISIT**

STUDENT'S ASTHMA DOCTOR **PHONE** **DATE OF LAST VISIT**

ASTHMA SEVERITY

Student's Asthma is: *(See Reverse side for definitions)*

❑ Mild Intermittent ❑ Mild Persistent ❑ Moderate Persistent ❑ Severe Persistent

PAST YEAR ASTHMA HISTORY

Please check all ASTHMA related answers to show what happened in the past year.

School days missed:	❑ None	❑ 1-5	❑ more than 5
Emergency Room visits:	❑ None	❑ 1-3	❑ more than 3
Hospital admissions:	❑ None	❑ 1-3	❑ more than 3
Student uses Peak Flow meter:	❑ Yes	❑ No	❑ Doesn't have one
Personal best reading:	_____		❑ Doesn't have one
Student uses a spacer:	❑ Yes	❑ No	❑ Doesn't have one
Student has inhaler at school:	❑ Yes	❑ No	

TRIGGERS

What starts your student's asthma attack? *(check all that apply)*

❑ Colds ❑ Animals ❑ Food ❑ Smoke ❑ Exercise ❑ Dust ❑ Weather

❑ Other _____

EARLY WARNING SIGNS

How does your student look, sound, act before an asthma attack? *(check all that apply)*

❑ Wheezing ❑ Coughing ❑ Chest tightness ❑ Pain in chest ❑ Pain in back

❑ Shortness of breath ❑ Difficulty breathing ❑ Little energy for play

❑ Other _____

MEDICATIONS

Medicine	How Much	Time Taken	Side Effects
AT HOME			
AT SCHOOL			
***30 MINUTES BEFORE EXERCISE*, USE THIS MEDICINE**			

***NOTE:* Please notify School Nurse if student required medication before school due to asthma symptoms.**

PLEASE REVIEW, SIGN, AND RETURN this form to the School Nurse.

- The information above is correct and should be used when managing my student's asthma at school.
- The School Nurse may share this Asthma Action Plan with all school personnel interacting with my student.
- The School Nurse may contact the family asthma doctor listed above to discuss this information.
- If the student is sent to the emergency department (ED), a follow-up report can be faxed to the School Nurse.
- I give permission to use the "Asthma Tool Kit," a back-up Albuterol inhaler at school (if available).

PARENT / GUARDIAN SIGNATURE **DATE**

4/06 REVISED

Student Asthma Action Plan

Helping parents understand Asthma Severity Classification

The information presented here is to help parents to understand how asthma severity classifications are defined. NOT ALL CHILDREN FIT PRECISELY INTO THIS CLASSIFICATION. This information is provided to assist parents in working with their Asthma Doctor in the development of a Student Asthma Action Plan.

Before treatment is started, a child's asthma severity is determined according to various criteria. These criteria often overlap. The most severe step in which any criteria occur is used to classify the child's asthma. Your Doctor may assign a severity classification while your child is taking medication but still hasn't achieved best control.

SYMPTOMS	CLASSIFICATION
Does your child: Cough, wheeze, or has shortness of breath- LESS THAN two times a week Short duration of symptoms (generally a few hours to a few days) Nighttime asthma symptoms no more than two times per month Between episodes, is symptom free Peak Flow GREATER THAN 80% of personal best (green zone)	**MILD INTERMITTENT**
***OR* has:** Persistent symptoms Episodes MORE THAN two times per week Nighttime asthma symptoms MORE THAN two times per month Peak Flow GREATER THAN 80% of personal best (green zone) Cough variant asthma	**MILD PERSISTENT**
***OR* has:** Daily symptoms Episodes affecting activity and sleep Nighttime asthma symptoms MORE THAN one time per week Daily use of short-acting inhaler Peak Flow GREATER THAN 60% but LESS THAN OR EQUAL TO 80% of personal best (yellow zone)	**MODERATE PERSISTENT**
***OR* has:** Continuous symptoms Frequent episodes Frequent nighttime asthma symptoms Physical activities limited by asthma symptoms Severe episodes in spite of medication Peak Flow LESS THAN 60% personal best (red zone)	**SEVERE PERSISTENT**

After your child's asthma is under control, your Doctor may classify your child's asthma according to the treatment needed to maintain control. For example:

Mild intermittent – no daily medication is needed.
If your child starts using a rescue medication more than 2 times per week your Doctor may suggest the need to start long-term control medication.

Mild persistent – one daily long-term control medication is necessary.

Moderate persistent – inhaled corticosteroids with or without additional long-term control medications as indicated.

Severe persistent – multiple long-term control medications are required, including high-dose inhaled corticosteroids and, if needed, oral corticosteroids.

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