Erin Matyjasik, PhD, NCSP
Special Services Director
Health Services Department

ENVISION 21
DEEP LEARNING • CFSD

Phone: (520) 209-8081
ematyjasik@cfsd16.org
www.cfsd16.org

ASTHMA ACTION PLAN

*School:*_____ *Year*_____

Student name:	Date of Birth:	Grade:

Green Zone: Doing Well

Symptoms: breathing is good - No cough or wheeze

Control Medications:

Medicine	Dose/How much to take	When/how often to take it	Take at school
_____	_____	_____	Yes No
_____	_____	_____	Yes No

Physical Activity: Use Albuterol/Levalbuterol ____ puffs 15minute before activity with all activity when child feels they need it

Yellow Zone: Caution

Symptoms: Some problems breathing - Cough, wheeze or chest feels tight - Problems working or playing

Quick-relief Medicine: Albuterol/Levalbuterol ___ puffs, every 4 hours as needed other:_____
Control Medicine(s): Continue Green Zone medicines
Add: _____ Change to: _____

The child should feel better within 20-60 minutes of the quick-relief treatment. If the child is getting worse or is in 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: A lot of problems breathing - cannot work/play - getting worse, not better - medicine not working

TAKE QUICK-RELIEF MEDICINE NOW: Albuterol/Levalbuterol ___ puffs, _____(how frequent)

CALL 911 IMMEDIATELY IF THE FOLLOWING DANGER SIGNS ARE PRESENT:

- ➢ Trouble walking/talking due to shortness of breath
- ➢ Lips or fingernails are blue
- ➢ Breathing difficulty developed ***rapidly***
- ➢ Still in the RED ZONE after 15 minutes

("Asthma Action Plan for Home and School," American Lung Association, LUNG.org, 1-800-LUNGUSA)

**This is confidential information. Under FERPA law, each staff member that has this information has the responsibility to prevent inadvertent disclosure and is to store protected health information in a secure location. Please contact the school nurse if you have any questions.*

**This Individualized Health Plan provides for routine accommodations that the Catalina Foothills School District (CFSD) makes available to any student who needs such routine accommodations. This IHP is separate and does not require a 504 plan or Individualized Education Plan (IEP) to accompany it.*

Parent/Guardian Signature: _____ Date: _____
School Nurse Signature:_____ Date: _____

Revised 11/2019