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, 15 minutes before activity
☐with all activity ☐when you feel you need it

Yellow Zone: Caution

Symptoms: Some problems breathing - 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

Emergency Contact Name _____ Phone (_____) _____-_____

Healthcare Provider Name _____ Phone (_____) _____-_____

1-800-LUNGUSA | LUNG.org

Date ____/____/_____

Bement Community Unit School District #5

Superintendent of Schools
201 S. Champaign
Bement, IL 61813
(217) 678-4200 Ext. 3

Bement Grade-Middle School
201 S. Champaign
Bement, IL 61813
(217) 678-4200 Ext. 2

Bement High School
201 S. Champaign
Bement, IL 61813
(217) 678-4200 Ext. 1

Asthma Medication Self-Administration

Date _____

Dear Parent/Guardian,

The Bement Elementary & Middle School has received your request for self-administration of the medication _____ for your

child _____.

State law requires that we inform the parents or guardians of the student, in writing, that Bement Community School District #5 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 student.

Before we can allow your child _____ to self-administer the medication, we must ask that you sign and return a copy of this document.

The permission for self-administration of medication is effective for the school year for which it is granted and shall be renewed each subsequent school year upon fulfillment of the requirements outlined above. We recommend that you provide an additional dose of the medication to be kept at school in the event that your child forgets or loses his/her medication.

I _____,

parent or guardian of _____, acknowledge that the Bement School District #5 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 above named student. I indemnify and hold harmless the school district and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the self-administration of medication by the student.

Signed_____

Date_____

Witness_____