MATHIS INDEPENDENT SCHOOL DISTRICT **SCHOOL HEALTH SERVICES**	EMERGENCY HEALTH CARE PLAN **Asthma Action Plan**

Student: _____DOB: _____Grade: _____

Severity of reactions (s): _____

Mother: _____ Cell#: _____Home#: _____ Work#: _____

Father: _____ Cell#: _____Home#: _____ Work#: _____

Emergency Contact: _____Relationship: _____ Phone #: _____

I give consent to follow the plan of action as directed below by my child's physician:
Parent/Guardian Signature: _____ Printed Name: _____Date: _____

Below To Be Completed By Physician Only

GREEN Zone	**PREVENTATIVE PLAN**	**You are doing well with no cough, wheeze or shortness of breath day or night. Use controller medicines daily at home. May use Albuterol or Xopenex 1 or 2 puffs before exercise as needed.**
YELLOW ZONE	**RESCUE PLAN**	**Symptoms being: Cough, Wheezing, Shortness of breath, Chest tightness, breathing fast or heavy, waking up at night with cough or exercise limitation. Continue controller medicines daily at home.** **Give: (Reliever Medication)** • **Albuterol or Xopenex by inhaler 1 or 2 puffs four times daily as needed OR** • **_____by inhaler ___or _____ puffs _____ daily as needed**
RED ZONE	**EMERGENCY PLAN**	**You are very short of breath with difficulty walking or talking.** **Cough or wheeze is constant.** **Neck or stomach muscles are used to breathe.** **Reliever medications are not helping.** **Give:** • **A second dose of reliever medication in 20 minutes OR** • **A second dose of reliever medication in _____ minutes.** • **And notify parent/guardian. Have parent/guardian pick up student.** **If you cannot say a full sentence in one breath or if you are struggling to breathe, call 911 or go to the nearest hospital emergency room.**
ON AIR QUALITY ALERT DAYS		**_____No outdoor exercise** **_____ Exercise as tolerated** **_____Limited outdoor activity (No sprints/running)** **_____ Unrestricted**

ATTENTION PHYSICIAN	**It is my profession opinion the above student be allowed to carry and self-administer his/her inhaler while on school property and/or school related events. Inhalers without orders to carry and self-administer are kept locked in the school health clinic.**	**PLEASE CIRCLE** **SHOULD / SHOULD NOT** **Physician's Initials: _____**

Physician's Signature: _____ Initials: _____ Date: _____

Physician's Printed Name: _____