

Asthma Action Plan Kearney School District

Must be completed by Physician

Name _____ Teacher/Team _____

Emergency Contact _____ Phone _____

Physician _____ Phone _____

Physician Signature _____ Date _____

Triggers		Exercise	
<input type="checkbox"/> Air Pollution	<input type="checkbox"/> Animals	Medications before exercise:	
<input type="checkbox"/> Colds	<input type="checkbox"/> Dust		
<input type="checkbox"/> Exercise	<input type="checkbox"/> Foods	Modifications for exercise:	
<input type="checkbox"/> Smoke	<input type="checkbox"/> Weather		

GREEN ZONE: Doing Well

- Breathing is good
- No cough or wheeze
- Attending school
- Playing and Active
- Sleeping well

Peak Flow Meter Personal Best= _____

Control Medications : Amount How often

Peak Flow meter 80% of personal best or _____

YELLOW ZONE: Getting Worse

- Some breathing difficulties
- Cough, wheeze, tight chest
- Missing school or work
- Difficulty with activity
- Waking at night
- Avoid triggers
- Taking regular medications

Contact Physician if using quick relief more than 2 X week.

Continue control medications and ADD:

Medication Amount How often

Peak Flow meter 50-80% personal best or _____

RED ZONE: MEDICAL ALERT!

- Panic, out of control
- Breathing hard and fast
- Medicine is NOT helping
- Can not do activities
- Avoid triggers

Call 911 & Emergency Contact Number: if still in RED ZONE after 15min

Lips or fingernails turn blue or trouble talking due to shortness of breath!

Continue control medications and ADD:

Medication Amount How often

Peak Flow meter 50-80% personal best or _____ to _____