



Quentin
Road
Christian
Preschool

ASTHMA ASSESSMENT AND ACTION PLAN



Date: _____

Child's Name: _____ Birthdate: _____ Age: _____

Classroom: _____

DAILY ASTHMA ACTION PLAN

- Check all of the things which may start an asthma episode in your child:

<input type="checkbox"/> Exercise	<input type="checkbox"/> Strong odors or fumes	<input type="checkbox"/> Other _____
<input type="checkbox"/> Respiratory infections	<input type="checkbox"/> Chalk dust	
<input type="checkbox"/> Change in temperature	<input type="checkbox"/> Carpets in the room	
<input type="checkbox"/> Animals	<input type="checkbox"/> Pollens	
<input type="checkbox"/> Food _____	<input type="checkbox"/> Molds	

- List any environmental control measures, pre-medications, and/or dietary restrictions that your child needs to prevent an asthma episode:

- Peak Flow Monitoring:

Personal Best Peak Flow Number: _____

Monitoring Times: _____

- Daily Medication Plan (taken at home):

GREEN ZONE- No asthma symptoms, able to do all activities, or medication to prevent exercise induced asthma

Name

Dosage

1. _____
2. _____
3. _____

YELLOW ZONE: asthma symptoms-cough, wheeze, short of breath, limited activities

Emergency action is necessary when your child has the following symptoms: _____

_____.

Emergency action is necessary when your child has a peak flow reading of: _____.

● **Steps to take during an asthma episode:**

1. Give rescue medications listed below
2. Have child return to classroom if _____
3. Contact parent if _____
4. Seek emergency medical care (CALL 911) if the student has any of the following:

RED ZONE:

- **No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached.**
- **Peak flow of _____**
- **Fast or Hard time breathing with:**
 - **Chest and neck pulled in with breathing**
 - **Child is hunched over**
 - **Child is struggling to breathe**
- **Trouble walking or talking**
- **Stops playing and can't start activity again**
- **Lips or fingernails are gray or blue**

● **Emergency Asthma Medications to be Taken at School (requires medication authorization on file):**

Name	Dosage	Exp. Date	When to Use
1.			
2.			
3.			
4.			

Dr. Name:	Dr. Phone #:
Dr. Signature:	Date:

Has the child been instructed in:

_____ Warning signs/symptoms of asthma attack? _____ Use of inhaler _____ Use of Peak Flow Meter?

_____ Parent Signature _____ Date